# THE AMERICAN JOURNAL of PSYCHIATRY

VOLUME 110
NUMBER 4
OCT. 1953

Official Organ of
THE AMERICAN
PSYCHIATRIC
ASSOCIATION

# THE AMERICAN JOURNAL OF PSYCHIATRY

VOLUME 110 OCTOBER, 1953 No. 4



*Published by*

THE AMERICAN PSYCHIATRIC ASSOCIATION

1601 EDISON HIGHWAY, BALTIMORE 13, MD.

# AMERICAN JOURNAL OF PSYCHIATRY

## INFORMATION FOR CONTRIBUTORS

**Manuscripts**—The *original* manuscripts of papers read at the annual meetings of the Association should be deposited with the Secretary during the meetings, or sent to the New York office promptly afterward. Do not deposit carbon copies.

Papers read at the annual meetings become the property of the Association. Not all papers read however can be published in the JOURNAL, and authors wishing to publish in other vehicles will first secure from the Editor the release of their manuscripts.

Papers will not be accepted for the annual program if they have been previously read at other meetings or if they have been already published.

Papers contributed during the year (not on the annual program) should be sent to the Editor, Dr. Clarence B. Farrar, 216 St. Clair Avenue West, Toronto 5, Ontario, Canada.

**Style**—Manuscripts should be typewritten, double spaced, on one side of paper. They must be prepared in conformity with the general style of the American Journal of Psychiatry. Retain a carbon copy of manuscript and duplicates of tables, figures, etc., for use should the originals be lost in the mails.

**Multiple Authorship**—The number of names listed as authors should be kept to a minimum, others collaborating being shown in a footnote.

**Illustrations**—Authors will be asked to meet printer's costs of reproducing illustrative material. Copy for illustrations cannot be accepted unless properly prepared for reproduction. Wherever possible, drawings and charts should be made with India ink for photographic reproduction as zinc etchings. Photographs for halftone reproduction should be glossy prints. Illustrations should be as small as possible without sacrificing important detail. Redrawing or preparing illustrations to make them suitable for photographic reproduction will be charged to author.

**Author's Corrections in Proofs**—Corrections, additions or deletions made by authors are to be charged to them. These alterations are charged on a time basis at the rate of $3.00 per hour. Proper editing of original manuscript is important to avoid the expense of correction.

**Tables**—Tables should be typed and on separate sheets. Tables are much more expensive to set than text material and should be used only where necessary to clarify important points. Authors will be asked to defray cost of excessive tabular material.

**References**—References should be assembled according to author in a terminal bibliography, referred to in text by numbers in parentheses. Bibliographical material should be typed in accordance with the following style:

1. Vander Veer, A. H., and Reese, H. H. Treatment of schizophrenia with insulin shock. Am. J. Psychiat., 95: 271, Sept. 1938.

Abbreviations should conform to the style used in the Quarterly Cumulative Index Medicus.

---

The American Journal of Psychiatry, formerly the American Journal of Insanity, the official organ of The American Psychiatric Association, was founded in 1844. It is published monthly, the volumes beginning with the July number.

The subscription rates are $12.00 to the volume: Canadian subscriptions, $12.50; foreign subscriptions, $13.00, including postage. Rates to medical students, junior and senior internes, residents in training during their first, second, or third training year, and also to graduate students in psychology, psychiatric social work, and psychiatric nursing, $5.00 (Canada $5.50). Single issues $1.25.



Office of Publication, 1601 Edison Highway, Baltimore 13, Md.

Editorial communications, books for review and exchanges should be addressed to the Editor, Dr. Clarence B. Farrar, 216 St. Clair Avenue West, Toronto 5, Ontario, Canada.

Business communications, remittances and subscriptions should be addressed to The American Psychiatric Association, 1601 Edison Highway, Baltimore 13, Md., or to 1270 Avenue of the Americas, New York 20, N. Y.

Entered as second class matter July 31, 1911, at the postoffice at Baltimore, Maryland, under the Act of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized on July 3, 1918.

OCTOBER **CONTENTS** 1953

# THE AMERICAN PSYCHIATRIC ASSOCIATION

## OFFICERS 1953–1954

*President:* KENNETH E. APPEL, M. D.
*President-Elect:* ARTHUR P. NOYES, M. D.
*Secretary:* R. FINLEY GAYLE, JR., M. D.
*Treasurer:* HOWARD W. POTTER, M. D.

## COUNCILLORS

| For 3 years | For 2 years | For 1 year |
|---|---|---|
| D. EWEN CAMERON, M. D. | HENRY A. DAVIDSON, M. D. | FRANK J. CURRAN, M. D. |
| S. SPAFFORD ACKERLY, M. D. | FRANCIS J. GERTY, M. D. | WILLIAM B. TERHUNE, M. D. |
| MAURICE LEVINE, M. D. | FRANK F. TALLMAN, M. D. | JOHN C. WHITEHORN, M. D. |
| PAUL L. SCHROEDER, M. D. | LEO H. BARTEMEIER, M. D. | WALTER E. BARTON, M. D. |

## EXECUTIVE COMMITTEE

KENNETH E. APPEL, M. D.
ARTHUR P. NOYES, M. D.
R. FINLEY GAYLE, JR., M. D.
HOWARD W. POTTER, M. D.
FRANCIS J. GERTY, M. D.
WALTER E. BARTON, M. D.

## MEDICAL DIRECTOR

DANIEL BLAIN, M. D., 1785 Massachusetts Avenue, N. W., Washington 6, D. C.

## EXECUTIVE ASSISTANT

AUSTIN M. DAVIES, PH. B., 1270 Avenue of the Americas, New York 20, N. Y.

## CHAIRMEN OF COMMITTEES

### ANNUAL COMMITTEES

*Arrangements*
EDWIN GILDEA, Chairman
MARGARET GILDEA, Chairman, Ladies Committee

*Nominating*
HENRY BROSIN, Chairman

### STANDING COMMITTEES
(Internal Activities of Association)

*Budget*
ROBERT H. FELIX

*Constitution and By-Laws*
MORRIS HERMAN

*Ethics*
WALTER P. GARDNER

*Membership*
HERBERT S. GASKILL

*Program*
DAVID A. YOUNG

*Resolutions*
IVAN C. BERLIEN

### STANDING COMMITTEES
(Technical Aspects)

*Child Psychiatry*
MARGARET GILDEA

*History of Psychiatry*
GREGORY ZILBOORG

*Medical Education*
THEODORE LIDZ

*Medical Rehabilitation*
BENJAMIN SIMON

*Public Health*
PAUL V. LEMKAU

*Research*
JACQUES GOTTLIEB

*Therapy*
PAUL HOCH

### STANDING COMMITTEES
(Professional Standards)

*Clinical Psychology*
PAUL HUSTON

*Legal Aspects of Psychiatry*
WILLIAM H. HAINES

*Nomenclature and Statistics*
GEORGE N. RAINES

*Psychiatric Hospital Standards and Policies*
ADDISON M. DUVAL

*Psychiatric Nursing*
H. BECKETT LANG

*Psychiatric Social Service*
JULES V. COLEMAN

### STANDING COMMITTEES
(Community Aspects)

*Academic Education*
BARUCH SILVERMAN

*Industrial Psychiatry*
RALPH T. COLLINS

*International Relations*
IAGO GALDSTON

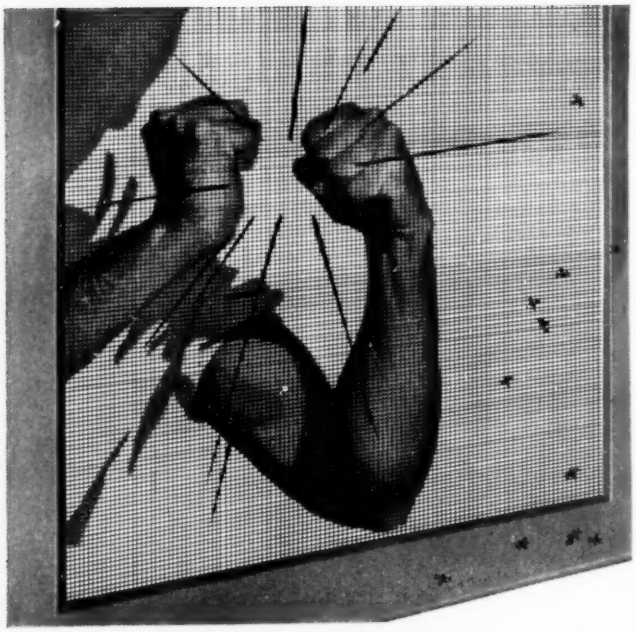
*Cooperation with Leisure Time Agencies*
ALEXANDER R. MARTIN

*Military Psychiatry*
JOSEPH S. SKOBBA

*Preventive Psychiatry*
LLOYD L. THOMPSON

*Public Information* (formerly Committee on Public Education and Relations)
WILFRED BLOOMBERG

*Veterans*
DAVID J. FLICKER



# Chamberlin Security Screens provide maximum detention; eliminate *all* insect screen costs

**You save all insect screen costs.** Close-woven, high-tensile-strength wire of Chamberlin Security Screens takes place of insect screening, withstands years of violent abuse. Admits ample light and air.

**You cut sash repairs and painting costs.** Chamberlin Security Screens, mounted at recommended distance from windows, stoutly resist attack, help prevent costly damage to window frames, sash, paint.

**You reduce glass breakage.** Inside mounting of Chamberlin Security Screens reduces window-glass breakage, cost of glass replacement, patient injury.

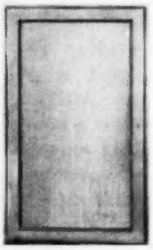
**You reduce the threat of disaster.** No grilles, no bars to trap your patients in a fire. No stubborn locks hinder their rescue. Exclusive Chamberlin emergency release permits instant patient removal from outside.

**You cut grounds maintenance costs.** Patients can't throw litter out of window, can't store it on window sill, can't receive forbidden objects by pass-in.

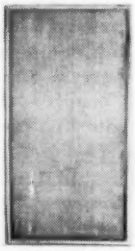
Over the years, these savings will more than offset your original costs. Yet they're only *part* of the savings and services other hospital administrators count on every day (see right). Let our Hospital Advisory Service give you full details. Write today.

**The right screen at the right cost to fit your patients' needs**

Detention Type



Protection Type



Safety Type

Chamberlin Detention Screens provide *maximum* detention and protection. Their heavy steel frames wired with high-tensile-strength wire cloth suspended by concealed springs to absorb shock, reduce injury to both patient and screen. Chamberlin Protection and Safety Screens provide suitable and economical protection for nonviolent patients.

## QUICK NOTES

**on savings and services provided by Chamberlin Security Screens**

In the last fourteen years, over 80,000 Chamberlin Security Screens have provided these and additional savings and services to hundreds of hospitals in almost every state of the U.S. and in numerous foreign countries.

**Chamberlin Security Screens reduce maintenance time, effect material savings;** replace heavy bars and guards. Replace insect screens. Stop glass breakage and damage to window frames and sash. Reduce painting requirements. Reduce grounds maintenance work by keeping litter in rooms.

**They reduce cost of medical care for physical injury:** prevent self-damage and attacks on attendants with broken glass. Prevent cold-inducing drafts. Prevent suicide attempts by hanging from window muntins, grilles, bars. Prevent receipt of dangerous pass-in objects.

**They provide more cheerful atmosphere.** Supplant depressing jail-like bars and grilles. Make room interior more homelike; keep building's exterior uncluttered. Admit ample light and summer air.

**Chamberlin Security Screens *supplement* supervision.** Special Chamberlin locking device resists tampering and plugging attempts. Close-woven, high-tensile-strength wire mesh foils usual picking and prying. Smooth frame edges and rounded corners preclude accidental or intentional self-damage. Screens can be provided with emergency release permitting instant patient removal by operation of lock from outside.

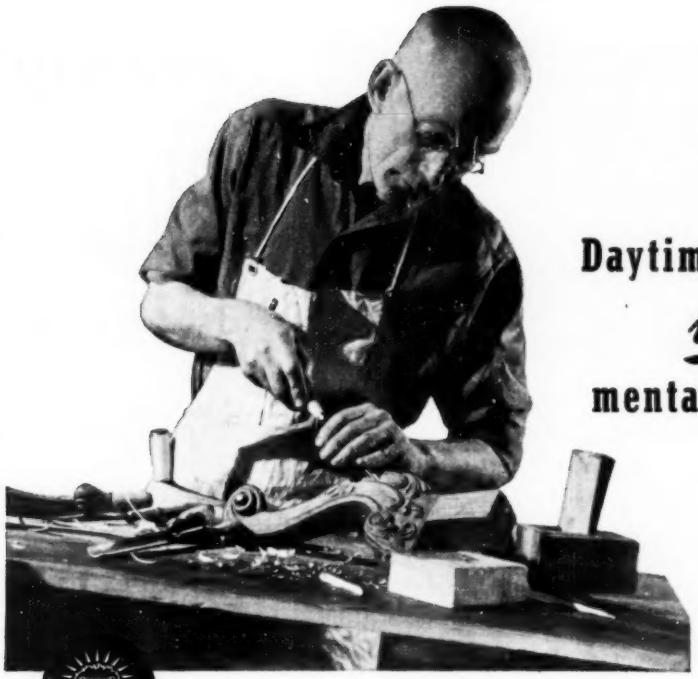
Modern institutions turn to CHAMBERLIN
CHAMBERLIN COMPANY OF AMERICA
For modern detention methods

**CHAMBERLIN COMPANY OF AMERICA**

*Special Products Division*

**1254 LA BROSSE ST. • DETROIT 32, MICH.**

**CHAMBERLIN INSTITUTIONAL SERVICES also include Rock Wool Insulation, Metal Weather Strips, Caulking, All-Metal Combination Windows, Insect Screens, Building Cleaning, Tuck Pointing, and Waterproofing.**



## Daytime sedation *with* mental alertness

# MEBARAL®

BRAND OF MEPHOBARBITAL

*—in depressed and agitated states*

**psychoneurosis**
**hypertension**
**hyperthyroidism**
**convulsive disorders**
**difficult menopause**
**hyperhidrosis**

Neurotic depression hiding beneath the disguises of multiple physical complaints is an everyday problem in medical practice.

For effective sedation in these cases, and as a means of restoring harmonious relations between patient and environment, Mebaral has been found especially suitable because it lacks excessive hypnotic action.

DOSAGE:

**Adults**—32 mg. to 0.1 Gm. (optimal 50 mg.), 3 or 4 times daily.

**Children**—16 to 32 mg., 3 or 4 times daily.

SUPPLIED:

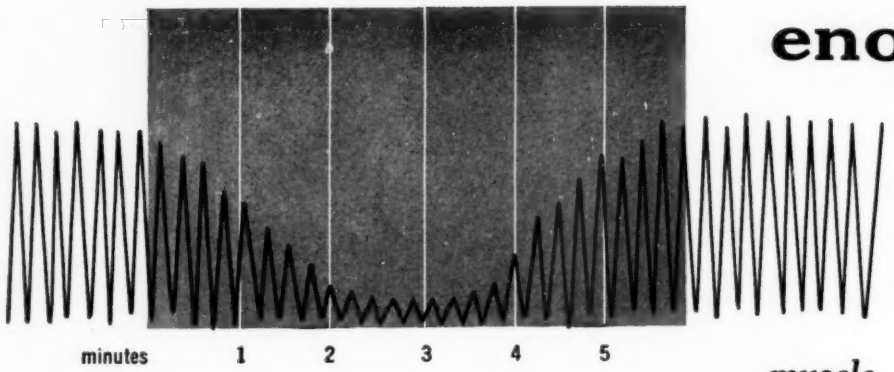
Tablets of 32 mg. (½ grain)
50 mg. (¾ grain)
0.1 Gm. (1½ grains)
0.2 Gm. (3 grains) scored

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Mebaral, trademark reg. U. S. & Canada

WINTHROP-STEARNS INC. New York 18, N. Y. • Windsor, Ont.

# brief enough




*muscle relaxation for E. C. T.*

No longer need the advantages of muscle relaxation during electro-convulsion therapy be foregone because of the disadvantage of prolonged effect. Speed of action and recovery are characteristics of 'Anectine' medication.

'Anectine' produces full relaxation within 90 to 120 seconds of injection; the effect lasts about 2 minutes, and recovery of muscle tone begins immediately thereafter.

As with all relaxants, facilities for oxygen insufflation must be available when 'Anectine' is given. When apnea does occur, its average duration is about 2 minutes.

References: Wilson, W. and Nowill, W. K.: Southern Psychiatric Meeting, 1952.

Holmberg, G. and Thesleff, S.: Am. J. Psychiat. *108*:842, 1952.

# 'Anectine' *Chloride brand*

**SUCCINYLCHOLINE CHLORIDE INJECTION**

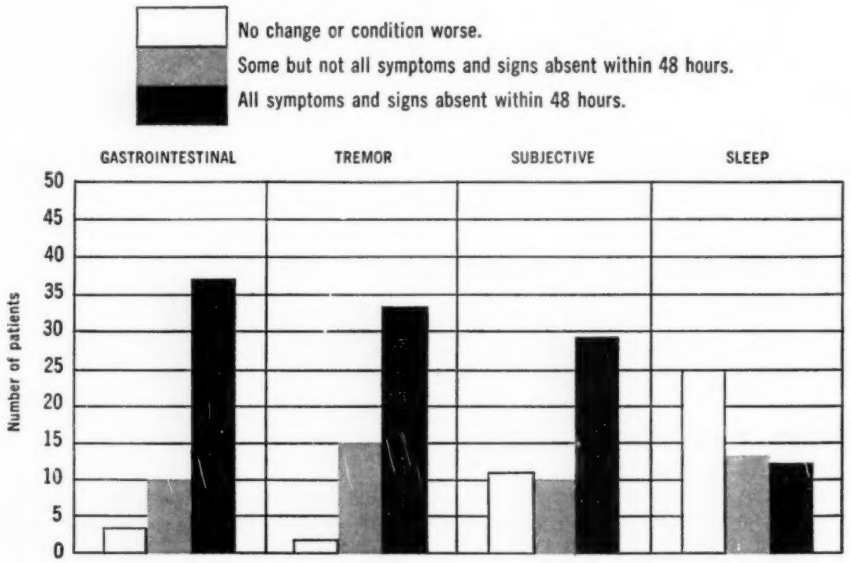
20 mg. in each cc.
Multiple-dose vials of 10 cc.
Ready for intravenous injection.

*For full information, write to –*

**Burroughs Wellcome & Co. (U.S.A.) Inc.,** *Tuckahoe 7, N. Y.*

# "of decided benefit in the management of the postalcoholic state"*

***The effect of oral Tolserol in 50 alcoholic patients****




*Herman, M., and Effron, A. S.: Quart. J. Stud. Alcohol 12:261 (June) 1951.

## . Tolserol

(*Squibb Mephenesin*)

**Tablets,** 0.5 and 0.25 gram. Bottles of 100.
**Capsules,** 0.25 gram. Bottles of 100.
**Elixir,** 0.1 gram per cc. Pint bottles.
**Intravenous Solution,** 20 mg. per cc. 50 and 100 cc. ampuls.
**Tolserol With Codeine Tablets,** 0.5 gram Tolserol and 1/8 grain codeine sulfate. Bottles of 100.

**SQUIBB**


# EUPHASED

Trademark

[d-DESOXYEPHEDRINE HYDROCHLORIDE AND ACETYLBROMDIETHYLACETYLCARBAMID SCHENLEY]


combines mood-lifting desoxyephedrine (more potent but less upsetting than amphetamine[1]) with gentle, calming Sedamyl* (*not* a barbiturate)

**SUPPLIED:** In bottles of 100 tablets
Each tablet contains:
2.5 mg. d-desoxyephedrine hydrochloride
0.26 Gm. (4 gr.) Sedamyl (acetylbrom-diethylacetylcarbamid Schenley).

1. Douglas, H. S.: West. J. Surg. 59:238, 1951.

**schenley**

**SCHENLEY LABORATORIES, INC. Lawrenceburg, Indiana**

# LETTER FROM FRANCE

V. J. DURAND, M. D., SAINT-VENANT, FRANCE

Since the World Congress in Paris in 1950, French psychiatry has followed the trends defined at that time by Professor Delay in his inaugural address.

Three outstanding events have marked the last 2 years. On May 25 and 26, 1952, was celebrated formally, in the presence of numerous foreign delegates, the centenary of the Société Médico-Psychologique. Among its founders in 1852 were Ferrus, Brierre de Boismont, Baillarger, Delasiauve, Falret, Moreau de Tours, Voisin. During the century that followed the Société has included in its membership all the great names in French psychiatry and has played a very significant role in the evolution of theoretical and therapeutic concepts in psychopathology. Among important communications presented during the anniversary ceremony was that of Delay on shock and the alarm reaction in psychiatry.

In July 1951, the Congress of Psychiatrists and Neurologists convened at Rennes. At this meeting Lafon (Montpellier) reported on behavior problems in children, urging a conservative position between undue pessimism and ill-considered optimism. Fontan (Lille) spoke on left-handedness, with conservative conclusions. Michel Cenac (Paris) took up the question of the value of evidence in court. Among other topics dealt with by the Congress were mythomania, the drawings of children, symptomatic affective retardation, suicidal attempts, group psychotherapy, psychosurgery, the use of lithium salts in psychiatric therapy, the treatment of alcoholism, and presenile psychoses.

In July 1952, the 50th annual meeting of the Congress of Psychiatrists and Neurologists was held in the capital of the Grand Duchy of Luxembourg. Kammerer (Strasbourg) presented a report on what psychiatry has learned from the study of twins, pointing out the discrepancy between the perfection of statistical method and the heterogeneity of the clinical syndromes observed, but giving some hope of progress in reconciling these methods of study. New concepts on meningeal hemorrhage in adults were presented by Géraud (Toulouse), while Donnadieu (Bordeaux) dealt with the subject of treatment for the tuberculous mental patient. Other communications were devoted to the subjects of psychopathology, psychosomatic medicine, therapeutics, and forensic medicine.

Barbé published a "Précis de Psychiatrie" following in general classical lines; while Baruk expressed his personal point of view in a manual basically experimental and physiological but reflecting also humanistic and ethical values. This attitude was developed further in his "Psychiatrie Morale, Expérimentale, Individuelle et Sociale." Ey, author of the organic-dynamic concept, continued the publication of his "Études Psychiatriques," a veritable sequence of monographs reflecting his teaching, of which the completed series will form a new "Natural History of Mental Illness." Guiraud in his "Psychiatrie Générale," presented his individual view of psychiatric problems—a double-aspect, monistic viewpoint based on the identity of mind and body and seeking to establish a monistic psychiatry opposed to the organic-dynamic doctrine of Ey. In 1952, a new edition of Porot's "Manuel Alphabétique de Psychiatrie Clinique, Therapeutique et Médico-Légale" was brought out, presenting an improved and simplified arrangement of topics.

Faithful to old clinical tradition, many French psychiatrists continue their interest in symptomatology, seeking to refine psychological diagnosis, constructing tests such as that of Tsédèk, through which Baruk attempts to explore the ethical sense. Unfortunately, current application of tests is often hindered by the lack of medical or psychological personnel in many of the services. Equipment, on the other hand, is rapidly multiplying (EEG, apparatus for endocrine study, for example). Centers of biological research are developing, thus permitting useful observations, such as those of Paul Abély on endocrinological psychiatry; those of the university of Paris, Lyon, Marseille, Montpellier on the EEG, of Bordeaux on electroshock methods, of Strasbourg on psychological results of lobotomy; those of Baruk on

the numerous problems of the physiology of the nervous system.

The book by Hécaen and Ajuriaguerra on "Méconnaissances et Hallucinations Corporelles," that of Jean Lhermitte on hallucinations, that of the same author on "Mystiques et Faux Mystiques," the works on epilepsy of Marchand and Ajuriaguerra as well as of Roger and his pupils—these point up important questions in psychopathology.

French psychiatric centers, for a long time rather hostile to psychoanalytic doctrine, have gradually become somewhat more favorable, maintaining, nevertheless, a prudently critical attitude. Outside of the orthodox psychoanalytic circles, if the influence of the concepts of Freud, Adler, Jung, or Stekel is spreading, it has by no means attained the importance that it has in the United States or in Switzerland, for example. A degree of reserve continues. On the other hand, psychosomatic medicine has rapidly gained wide recognition, a long Hippocratic and humanistic tradition having always marked French medicine, which has never failed to consider man, and particularly a sick man, in his totality.

Problems of child psychiatry, not only those of mental retardation but also disorders of behavior, juvenile delinquency, and character disturbances, occupy an important place in France. Interest in these questions is evidenced in the creation of a chair of child neuropsychiatry in the Faculty of Medicine in Paris (Prof. Heuyer), the development of specialized services, of centers of re-education, and of medico-pedagogical institutes. A definite psychoanalytic trend is seen among psychiatrist-pediatricians. Progress in the fields of pharmacology, psychotherapy, surgery (leucotomy, jugulo-carotid anastomosis) has been taken full advantage of in child psychiatry. The manuals of Robin and of Michaux, and Heuyer's "Introduction to Child Psychiatry," recently published, are notable in this department of psychopathology.

Therapeutic questions are always among the first preoccupations of French psychiatrists. With the exception of a few, especially Baruk, the majority are favorable to shock therapy. Jean Delay's book on therapy described the situation in 1950. While cardiazol (pentamethylenetetrazole) is much less used than formerly, electroshock is used on a larger scale, with indications that are now quite specific. Electronarcosis has been in use for more than 2 years, as well as the method of prolonged electroshock at low intensity. This latter procedure has proved very useful in place of ordinary electroshock in a great many cases. The Sakel treatment, which has been utilized in France for more than 15 years, is still largely employed, but there are still opponents because of the possible accidents and the frequent relapses. Fiamberti's method, acetylcholine therapy in schizophrenia, is rarely resorted to, while the method of Meduna, carbon dioxide inhalation, is coming into more frequent use.

Laborit's method of artificial hibernation as made use of in surgery is also being applied in psychiatry and shows considerable promise. The same is true of the various methods of prolonged sleep. Studies have also been made of the effect of cortisone, ACTH, and serotherapy. Some observers, for example, Hyvert, continue to favor the use of tuberculin in the treatment of schizophrenia, on the assumption of a possible atypical tuberculosis. Glutamic acid and dinitrile succinyc acid are widely employed. Hormone therapy is increasingly used, especially by Abély, Baruk, Rondepierre, in a considerable variety of cases such as affective disorders, mental instability, personality disturbance, mental retardation, and demential states. Psychosurgery, having met at first with marked hostility, or at least an open scepticism, has latterly won much favor, but after a period of overenthusiasm its indications have been much more narrowly defined. Procedures have been widely varied, the lobotomy of Freeman and Watts and the topectomy of Poppen being most frequently used. Thalamotomy, transorbital leucotomy, cingulectomy are more rarely resorted to. Among methods specially used in France must be mentioned injections, through trepan openings, in the prefrontal lobes, of nonnecrosing substances whose action may be pharmacodynamic or hormonal (Paul Abély and Guyot). Ergotherapy has always been in high favor. Sociotherapy, Moreno's psychodrama, and group therapy are coming increasingly into use. However, personal dif-

ficulties in various psychiatric hospitals have prevented continuing such efforts as those of Sivadon to promote the rapid rehabilitation of patients. Narcoanalysis, following widespread use, seems to be somewhat less in favor and its indications more precisely defined. Pharmacological shock, particularly by use of amphetamine, is coming into more frequent use. Baruk, who is opposed to narcoanalysis, recommends a method akin to what used to be called moral treatment, and the creation of a friendly atmosphere. He attaches the name *chitamnie* to this type of psychotherapy.

The increase of alcoholism in France since the last war has raised serious problems, and although various methods of treatment, particularly the use of tetraethylthiuram disulfide, are widely current, the good results of such treatment are prejudiced by the paucity of special treatment and post-treatment centers.

It must be admitted that progress has been slower in the fields of mental hygiene and social psychiatry. Although there is an increased number of clinics and new specialized social services, there remains still much to be done. This has been most often due to financial difficulties. The same is true in accounting for somewhat retarded advances in forensic and penal psychiatry. Nevertheless it is possible to report considerable progress.

Taking account of research activities in the field of psychiatry the world over, France, true to her critical faculty, adheres to a conservative, watchful attitude. Among the diverse viewpoints and new theories she seeks to maintain a just balance equally removed from arid scepticism and ill-founded enthusiasm.

# BIOLOGICAL PSYCHIATRY[1]

A. E. BENNETT, M.D., BERKELEY, CALIF.

Biological psychiatry can be defined as the science of life in the relationships of living processes, both animal and vegetable, to mental illnesses. While the only expressed objective of our society is the study of the biological basis of behavior, I think we all have different concepts of the biological approach while believing that a broad concept of such a causation of mental illnesses is basically sound. Although psychogenesis is not rejected by most of us as one cause of major mental illnesses, certainly it is not the answer to most of our problems. The physiological approach has more nearly approximated specificity in therapy in a number of serious mental disorders. Examples are the antibiotics in neurosyphilis, nutritional and vitamin therapy in deliroid reactions, convulsive therapy in affective disorders. Even in some psychogenic emotional disorders physiological approaches cannot be ignored and often facilitate psychotherapy.

Anatomy, physiology, and pathology of the human body, influenced by hereditary and environmental factors, provide the only logical basis for explaining human behavior. Psychology and psychopathology furnish evidence of the function of the nervous system and its control of bodily systems. When general medicine finally correlates the physiological and biochemical reactions of the nervous system with psychogenic aspects then psychiatry will be on a scientific foundation. As knowledge of causation of mental illness increases, the number of so-called functional conditions decreases. The majority of psychiatric disorders are now accepted as organic. For example, research on the role of the thalamus, hypothalamus, frontal and temporal lobes, endocrine glands, and the role of nutrition in deficiency diseases and others has given us some basic factors in causation of abnormal behavior.

In his recent observations regarding brain mechanisms and behavior, particularly the role of the rhinencephalon, Kluver(1) emphasized Kubie's statement that "not one of the psychiatric discoveries of the past 50 years was made in this country." Hence the great need for intensive research in behavioral, physiological, and biochemical analyses of relationships between the rhinencephalon, neocortex, hypothalamus and endocrines. It is to be hoped that psychiatrists and psychoanalysts can participate in the great "psychiatric discovery" of the next half-century.

All mental disorders are a result of disturbances in the normal physiology of the body with consequent pathology, plus the influences of environmental factors. Henry Maudsley in 1770 said:

> The observation and clarification of mental disorders have been so exclusively psychological that we have not sincerely realized the fact that they illustrate the same pathological principles as other diseases. They are produced the same way and must be investigated in the same spirit of positive research. Until this is done I see no hope of improvement in our knowledge of them and no use in multiplying books about them.

I believe we are all much concerned about the current trend of overemphasizing psychodynamics as the answer to therapeutic psychiatry. Repeated mistakes resulting from neglect of the organic approach in a complete physical and neurological evaluation are seen almost daily in a busy practice and raise grave doubts as to whether many psychiatrists are practicing good comprehensive medicine.

Psychologists and other therapists have said that psychotherapy is not practicing medicine. The psychologist practicing psychotherapy in private practice does not assume responsibility for the health of the patient, it is claimed. When he recognizes the need for medical treatment, "he refers a client to a physician just the same as a lawyer might [do]." Yet, how can he consider himself qualified to recognize needs for medical treatment since this means the art of medical evaluation and diagnosis?

Huston(2) in his recent committee report on clinical psychology points out that care and treatment of the sick as the unique job of medicine is fundamental to the question

[1] Presidential Address before the Society of Biological Psychiatry, May 3, 1953, Los Angeles, Calif.

of who is qualified to give psychotherapy. All therapies, including psychotherapy, are grounded rationally upon basic sciences or empirically upon good medical practice. The problems of diagnosis and differential diagnosis are both complex and difficult and often continue to be problems throughout treatment. "Psychotherapy, *per se,* whenever sick people are involved always retains its medical orientation." Any therapist responsible for treatment of the sick must be always alert to the necessity for decisions regarding diagnosis and treatment. Individuals other than psychiatrists "may become highly skilled in some aspects of psychotherapy, but this does not entitle them to undertake broad responsibility for the treatment of the sick." They must therefore work in close, constant association with psychiatrists or other medical specialists. Clinical psychologists, for example, can contribute greatly to community knowledge by research in diagnostic methods and various aspects of treatment. This is a most important contribution, since "research in psychiatry is a crying need."

The psychoanalytic movement has come to resemble more a cult than a scientific discipline. Many orthodox analysts are compelled to submit their will and reason to as stern a discipline as are members of a religious order or a communistic or fascist group. The hierarchy inhabits a little world of its own out of touch with general medicine. Such isolation from medicine is a definite trend away from integration of psychiatry within general medicine. This trend is to be deplored; it does not further scientific progress in psychiatry. Our society represents a group dedicated to opposing this lack of balance between biological sciences and psychiatry.

Mental illnesses represent a failure to adapt adequately to a situation depending upon bodily, psychic, constitutional, genetic and social factors. Understanding the cause and treatment of mental illnesses means taking in all possible factors and requires all resources of medicine. A psychiatrist must be a physician prepared to deal with the total situation on many fronts, including somatic, psychic and environmental. Even constitutional and genetic factors cannot be ignored, though with present knowledge they may not be modifiable, *e.g.,* in the case of a birth injury with resultant constitutional defect; the development of schizophrenia in adolescence; or a case of cretinism fairly well compensated by continuous thyroid treatment until adolescence when the youth became hebephrenic.

Too often actual neurosis in the course of an analysis is replaced by a transference neurosis, which becomes as undesirable as the intolerable symptom complex for which the analysand is seeking permanent relief. The patient grows more dependent; the immature personality type is little altered; in no sense is the patient cured. Is this much different from Eddyism, in which illness is denied and one delusion replaces another?

Although statistical data are lacking, in the best hands completed analyses can claim only about 25% satisfactory results. Severe obsessive compulsive neurotics and others analyzed for years continue to be handicapped and are never cured. In contrast, we certainly obtain equally satisfactory results from much briefer psychotherapeutic procedures not closely related to depth psychology of the psychoanalytic type.

Genetic factors in schizophrenia or manic-depressive reactions seem to be obvious, but are denied by many analysts. The fact that the course of illness and personality patterns are often fundamentally changed by physical therapies does not impress them.

Are psychiatrists medical doctors? Frequently, the first question a patient asks at the initial interview is, "Doctor are you an M.D.?" The prevalence of this misunderstanding about psychiatry has troubled me. Why should so many laymen fail to differentiate us from clinical psychologists or to accept us as medical doctors? And yet, some experiences with my own patients and those of my colleagues have made me at times echo the question, *are psychiatrists M.D.'s?* When one finds mistakes in common neurological conditions, I think we have one answer.

For example, a young woman who had been treated for psychogenic headaches for several months entered our hospital with a clearly organic, psychotic reaction. Marked amblyopia had developed and bilateral six-diopter choked disks were immediately apparent. An emergency ventricular puncture

to prevent blindness was performed; later a ventriculogram revealed a parietal lobe astrocytoma. Such mistakes in diagnosis are inexcusable. It is doubtful whether the former psychiatrist ever used an ophthalmoscope in this case or carried out any neurological examination.

The endogenous midlife or involutional depressions represent another frequent failure to use proper therapy, thereby causing families much economic hardship and loss of time. These patients often have months or years of analytic psychotherapy without benefit, only to be completely relieved within a few weeks by convulsive therapy. Yet many of our colleagues condemn electroshock therapy or refuse to acquaint themselves with the indications and results obtainable in affective psychoses by its use.

Our specialty has been handicapped further by splintering off into separate groups such as psychoanalysts and child psychiatrists. These divisions tend to make psychiatry something apart from general medicine. Doctor Morris Fishbein, long identified with problems of medical specialization, stated:

> Medicine is being constantly more specialized, as witness the splintering of internal medicine into cardiology, gastroenterology, allergy, diseases of the chest, *etc.*, after having already split off neurology, diseases of metabolism, and some others. I observe requests for establishing a new board in pediatric cardiology. I was visited recently by a group who wanted to set up a special board in goiter, possibly including other diseases of the neck. It is not surprising then to find psychoanalysis as a technical specialty of psychiatry, and orthopsychiatry as an age division analagous to pediatrics and geriatrics.

On the other hand too much reliance upon physical therapy is harmful. In this respect a recent woman patient illustrates faulty diagnosis and treatment, with permanent harm:

> A midlife mild depression developed from a chronic neurotic illness and a complete thyroidectomy was done for typical anxiety symptoms. Shock therapy was next advised and 65 treatments were given, followed by 80 $CO_2$ inhalations, all on an ambulatory basis over a 15-month period. The costs ran as high as $20.00 to $25.00 per treatment, with frequent calls upon the family physician and special nursing care at home. A total memory loss for the 2 years previous to treatment resulted. There was some gradual return, but a year later the patient still showed gross sensorium defects and complete depersonalization, and required care like that of a child. EEG and Rorschach tests confirmed the impression of permanent organic defects. Such practice is again poor medicine and discredits psychiatric treatment. If shock therapy was indicated in the first place the patient needed hospitalization to accomplish a good result. Psychotherapy was totally ignored in the management of this patient.

An example of overemphasis upon psychotherapy is a recent case in our practice:

> A professional man who had had a depression for 1½ years, a diabetic with severe cardiac neurosis, had been so handled in a type of analytic psychotherapy that grave difficulties with a prolonged transference neurosis still remained. Actually, the patient had almost complete control of the therapy, and the mutually close relationship between the psychotherapist and him amounted to severe dependency. This is a comparable relationship to that existing in many medical cases in which the surgeon or internist by unnecessary, time-consuming surgery or medical procedures caters to the patient's hypochondriacism and dependency. The patient had become unable to work. Finally relatives insisted on bringing him to our inpatient service, where he responded well to brief, intensive therapy.

## HISTORICAL ASYLUM CONCEPT

Up to 40 years ago psychiatric diagnosis and treatment was entirely a state function, except for a few private sanatoria. In other words, mental illness was something apart from conventional medical practice something to be isolated usually in asylums and considered not a community problem but a field for state function. Asylum custody is the oldest and best example of state medicine. From time to time crusades to improve conditions in mental institutions have been made by heroes like Pinel, Tuke, Dorothea Dix, Clifford Beers and others.

As a rule sustained improvement has not resulted. Public apathy and changes in political leadership cause a letdown in public interest. Some progress has been made, but raising the level of psychiatric treatment is painfully slow. Will state or federal institutions ever reach standards of care comparable to that of private general hospitals? I have grave doubt that state or federal hospitals can ever meet the challenge of adequate care of mental illness. Tremendous overcrowding exists, trained personnel are hard to procure for state hospitals, and it is difficult to get patients to go early on a voluntary basis. By the time they are committed often they have developed chronic

illness, a condition that discourages most workers. More and larger institutions are being built but they cannot keep up with the increasing incidence of chronic mental illness.

May there not be something wrong with our policies? May not the concept of handling mental illness as a state function be at fault? Why should the management of mental illnesses be basically different from that of any other illness?

During the last 30 years a trend in medical practice to incorporate psychiatric medicine within general hospitals has grown a good deal. This is the most hopeful sign to relieve the "curse of psychiatric isolation." Successfully operated units get mental patients under treatment early, prevent chronicity, and keep the large percentage from ever reaching state hospitals.

The failure to integrate psychiatry properly into medical practice must rest with the failure to teach psychiatry adequately in medical schools and internships. Dr. Fishbein states:

> The condition results from the necessity for institutionalizing psychiatric patients of a previous generation and the failure to realize the tremendous part played by psychiatric factors in all diseases. In the International Congress on Medical Education to be held in London in August, 1953, the problem will be a major subject of discussion.

Last year a conference on psychiatric education conducted by The American Psychiatric Association and Association of American Medical Colleges published their report (3). There are no recommendations for the use of general hospital facilities for psychiatric education and from the report it appears that our educators fail to appreciate this need in modern medical education. Most medical colleges still use isolated state hospitals or adjacent psychopathic hospitals. Only 23 out of 47 schools for internship training use psychiatric units, wards, or beds in general hospitals.

Specifically, in our survey(4) of 72 4-year medical schools in the United States, 70 now make some use of general hospital psychiatry in psychiatric teaching and training. This high proportion, however, is rosier than closer inspection of figures would warrant. About two-thirds, or 49, of the 72 schools have access to full psychiatric treatment service in a general hospital, including outpatient service; 6 have access to partial services; 15 use outpatient service only in a general hospital setting; and 2 have no teaching service within a general hospital.

Of the 72 schools, 25 report that they teach psychiatry within a general hospital unit in all 4 undergraduate years. About the same number, 27, teach it in only the last 2 years, only 1 school teaches it in just the first 2 years, and 14 schools teach psychiatry in 1 year of the 4; 3 schools omitted an answer to this question.

One-fourth of the 72 schools, 13, use all general hospital departments in teaching psychiatry; 15 use medicine only; 25 use medicine plus 1 or more departments; and 17 use no departments except psychiatry.

In postgraduate training, 50 schools report accredited programs for residents within a general hospital psychiatric unit; 45 report accredited programs for interns; and 31 report accredited programs for psychiatric nurses.

For the most part, undergraduate training consists of ward walks, seminars, and case presentation as teaching methods, as reported by 69 schools. In a few instances, use of clinical clerkships is reported.

Very few internships, 198 out of 4,890 hospitals, include psychiatry. Psychiatric experience should become a universal requirement of internships. Most student nurses are required to have affiliate training with rotation in a psychiatric unit.

The overwhelming response in favor of integration of psychiatry with medicine in a query sent to internists is another proof that much more psychiatric teaching must be done within medical colleges. In order to ascertain the status of psychiatry as related to the rest of medicine, especially opinions concerning the value of psychotherapy and other special treatments, a questionnaire was sent to the heads of internal medicine of the medical colleges and to a few other representative clinicians. Six questions were formulated as follows:

1. In your medical practice do you get more help from the organically minded empirical type of psychiatrist or the analytic one who stresses psychodynamics?

2. What is your opinion as to the value of

prolonged psychotherapy in relieving chronic neurotic illness?

3. Do you favor establishing inpatient psychiatric departments and outpatient clinics in the general hospital?

4. In your opinion is psychiatric education and research improved by such integration of psychiatry into general hospitals or are results better in separate mental hospitals?

5. In what ways do you find psychiatric service disappointing?

6. Please suggest ways and means of best correlating psychiatry within medicine. Please give personal experience, if possible.

Replies were received from over half the internists and a few from other specialists. Their replies are summarized as follows:

To the first question, half replied that they got more help from psychiatrists organically minded; 20% reported better help from the analytic type of psychiatrist; and about 25% qualified their reply, preferring a combination of the 2 or suggesting analyses for severe neuroses and an organic approach for psychosomatic problems. Some stated that either was acceptable if the physician was interested, understanding, and sympathetic. A few had found very little help from either type. On the whole, leaders in internal medicine are definitely not favorably impressed with the analytic approach toward their psychiatric problems.

Some criticisms are very severe. For example, "one young man was made much worse after much psychoanalysis; he placed weird explanations into every act. The analysts did nothing to try to put him back on his feet. They were only interested in trying to dig around in his early sexual ideas." Another clinician stated that a schizophrenic youth who wanted to castrate himself was told he was perfectly sane and his trouble was due to the fact he wanted intercourse with his mother. This upset him all the more.

The more favorable reactions stress the value of the psychodynamic approach; others qualified it as "not psychoanalysis." Still others emphasized that it depends entirely upon an understanding, sympathetic therapist.

The answers to question 2 revealed clearly the attitude of medical men toward the value of prolonged psychotherapy. Over 50% pessimistically described it as: poor; no good; only occasional help; tends to prolong dependency; very opposed; patients continue neurotic for a lifetime. Only about 10% felt results were usually good or excellent. Again a few qualified their answers by such statements as: "little results in younger patients or those with high intelligence"; "occasionally good results"; "a necessary therapy"; "a more common-sense approach needed." Some were definitely antagonistic. A few reported excellent results in good hands, worse than none in poor hands. The general trend was decidedly pessimistic as to the value of prolonged psychotherapy.

Specific criticisms of prolonged psychotherapy are as follows: "It often yields diminishing returns—usually a patient can be given a reasonable insight in a short time. From then on he makes best progress by working on his problems with a minimum amount of guidance." "Helpful in some cases but cannot be routinized—common sense by the attending physician of greatest value in this situation." "I have seen very little help in the older age group, best results in young people." Another felt results excellent in good hands but too expensive in poor hands—"I have seen very little good accomplished." "Opinion not good, few cases helped and then only by prolonged transference and dependence upon the psychiatrist." "Opinion not very high—I'm pessimistic about its value—though there are individual exceptions."

Other replies pointed out: "Psychoanalysis during severe illness such as ulcerative colitis and peptic ulcer is dangerous and ill-timed. Too many cases of colitis perforate while under active psychotherapy." "Psychoanalysis certainly has a place and must be practiced. However, as we learn more about hormones, trace metals, etc., we observe how abnormal behavior patterns may be due to physical or chemical alteration or both, some of which are easily corrected. In the final analysis one must conclude that the broader is one's knowledge the better job can be done."

To question 3; 95% replied in favor of establishing psychiatry within general hospitals. Some were very emphatic about this need, and stated as their opinion that most of the difficulty with psychiatry has been caused

by isolation. A few favored outpatient clinics only, while 2 had no opinion.

Question 4 was likewise overwhelmingly in favor of integration of education and research in general hospitals instead of only in separate institutions; 95% were positive in their opinion. A few felt there was a place for both, and only 1 had no opinion. One stated that training would be better in separate institutions, another stated that psychotic patients should be separated. Several remarked about the much needed psychiatric liaison with internists and surgeons, *e.g.*, "Battle-scarred bellies show the need for surgeons."

In question 5 criticism of psychiatric service was expressed in a great variety of opinions. Twenty percent were most critical of therapy and its failure to get results. The next largest complaint was on the ground that psychiatrists fail to integrate their discipline with general medicine, or lack knowledge of medicine, or fail to pay enough attention to somatic factors. The third largest group complained that psychiatric service is not readily available, there are not enough well trained psychiatrists, and help is not easily obtained for minor problems. About 15% felt treatment too prolonged and too expensive. Isolated criticisms concerned terminology. The following are verbatim extracts: can't understand psychodynamics; too much emphasis upon theory; too much Freudism; no real interest in patient—only mental mechanisms; experience often traumatic, patients made worse; can't accomplish more than sensible internists; failure to assess results; not enough sensible psychiatrists.

Only 1 specialist reported no criticism at all. The over-all trend was very critical and in some instances definitely hostile. The reason can best be interpreted as the lack of integration and the isolation of psychiatry. We have failed to impress the rank and file of medical men favorably.

An example is the following statement:

> A psychiatrist poorly trained in medicine or who has a poor personality is a failure in psychiatric treatment. Psychiatry is an all or none subject. If a psychiatrist cannot crack the patient's shell and win his confidence he is a total failure. He cannot be half good or moderately good, he is a failure. Psychiatrists overlooking somatic diseases are as bad as somaticists overlooking the psyche. We should be doctors of the whole man. Too many of those practicing psychiatry are behavior problems and should be patients.

Question 6 likewise received a great variety of opinions with regard to ways to improve integration. Ten percent failed to answer. The large majority felt that the great need is closer working relationships in treatment through ward rounds and seminars with other specialties. Many mentioned the need for better psychiatric medical education of residents; a number recommended more training for general practitioners; some recommended short psychotherapy, direct supportive treatment, avoidance of long analyses. A few felt that internists should handle more minor problems and refer only severe cases. Several were critical of too ready use of shock therapy. Some pleaded for simpler terminology. It is interesting that none spoke for public enlightment.

From the questionnaire came a number of pertinent suggestions for aiding integration materially, all pertaining to better medical education. They were as follows:

1. Psychiatrists in attendance at all general medical clinics—psychiatric checkups; active consultive psychiatric services in the general hospital which give residents and interns in all services close exposure to psychiatry to their particular patient. Solution of the problem begins with the procurement of a chief of psychiatry interested both in the training of younger men and the further dissemination of psychiatric knowledge in the care of patients.

2. Since psychiatrists have worked with us on the medical wards the situation has been much improved; students now have some understanding of the psychology of illness—how better to approach and handle emotional problems and see the whole person more clearly than in the past.

3. Better screening of medical men before allowing further psychiatric training should be adopted. In psychiatric problems an internist with psychiatric insight is a valuable combination.

4. The best way is to teach doctors when still students in medical schools especially to develop correct attitudes.

A study by Ward(5), at the University of Michigan, on the problem of psychiatric re-

ferrals, confirms some of the findings in the questionnaire. Ward asked 26 residents and interns at the University Hospital 7 questions on the effectiveness of referrals.

One half were very critical of the service. Their chief criticism was that referrals are not helpful enough; suggestions for specific improvements were lacking. Other replies included such criticisms as: lack of interest in psychodynamics; too long waiting time; psychiatry helped too few people. The main recommendations of the group were: more direct specific advice on referral cases; improved liaison between services; and full information to other departments about the limitations of psychiatric treatment.

Dr. Desmond Curran(6), in his 1951 presidential address before the British Royal Society of Medicine criticized certain modern psychiatric trends, which he termed the "expansionist program." In his opinion some psychiatrists and psychotherapists make grossly exaggerated claims. Unfortunately the public has the idea that psychotherapy works miracles with the most unpromising material, and people are much aggrieved when it is pointed out in a busy outpatient session that their hopes are unfounded.

In his chairman's address before the 1952 meeting of the American Medical Association, Luton(7) discussed deficiencies of psychiatrists and their responsibility to medical colleagues. He emphasized the need to understand the attitude of referring physicians, the question of their participation in therapy, whether the physician knows how to work with the problem, whether there is an opportunity to teach and give help to the referring physician. He stressed the importance of educational programs within the community and programs for health teaching.

## THE PROBLEM FROM THE STANDPOINT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Our national association has, throughout the years, largely centered its activities on bettering conditions in state hospitals. Much less interest has been given toward integrating psychiatry within general medicine, despite the fact that about one third of the membership, 1,850 out of 5,680, engage in part-time or full-time private practice.

Muncie and Billings(8) surveyed conditions in private practice by questionnaires to private practicing members of The American Psychiatric Association. They found that only 11% have sufficient hospital facilities for their patients. One-third practice psychoanalysis exclusively; the others do general psychiatry. One-third of private practitioners use shock therapy, and 17% give office treatments. While more interest has been shown of late in general hospital psychiatry, it has never attained the status of a major objective by our associations.

The newly formed National Association for Mental Health in its initial report and solicitation of funds totally ignored the status of psychiatry in the general hospital as the logical point to start in prevention, since early recognition and effective treatment of mental illness are practical at the level of the general hospital.

## PRESENT STATUS OF GENERAL HOSPITAL PSYCHIATRY

Up to 1952 there were 293 general hospitals in the United States with either full or partial psychiatric service; 4,890 general hospitals provided 23,274 psychiatric beds or 4%. These beds accommodate only 1% of all mental patients. This is a strange situation, since emotional factors account for at least 25% of all admissions to general hospitals, and mentally ill patients actually fill more than half of all hospital beds. Canadian provinces show some realization of needs. Ontario pays $7,000 per bed to general hospitals that establish psychiatric units supplemented by an extra federal grant of $1,500 per bed; and 5 general hospitals have already applied for these funds. In this country a few organizations have favored development of psychiatry in general hospitals.

The Commission on Hospital Care reported in 1947 extensively on the problem of better psychiatric care within general hospitals. They recommended specifically that all general hospitals provide psychiatric inpatient and outpatient services and that they integrate the service with other special fields of medicine, especially training of personnel in psychiatric technics. The commission also recommended revision of commitment laws

to remove the stigma attached to admission for mental illness. The American Hospital Association enthusiastically endorsed these principles, but so far they have not been acted upon sufficiently.

One real problem in obtaining adequate treatment for mental patients is an economic one. Hospitalization is so expensive that few families can afford prolonged care; economic pressures thus constantly work against hospitalization of psychiatric patients. Voluntary health insurance plans seldom include psychiatric treatment in their benefits. We have recently reviewed all of these plans in our survey and pointed out ways to improve the situation. Eventually all acute illnesses, mental as well as physical, requiring hospital care will have to have some coverage if the voluntary prepayment plans are to function well. Present exclusion of all psychiatric disorders is unrealistic and definitely harmful to proper medical practice. At present all sorts of subterfuges are used to get coverage for the patient by erroneous diagnoses. At least 25% of all patients at all times in general hospitals are really psychiatric patients and yet are never so diagnosed when they have a health plan to cover hospital care. We have found that certain plans do cover psychiatric diagnosis and treatment, and operate very satisfactorily from the standpoint of cost and patient's satisfaction. In a few cases these are voluntary prepayment plans; in other cases they are group plans adopted by big corporations or unions. It is doubtful whether the plans can ever work out a practical way to cover psychotherapy in the office.

The recent Magnuson report of the President's Commission on Health Needs of the Nation gives valuable suggestions for integration of psychiatry within general medicine. Among the highlights, the report calls attention to the inadequacy of present prepayment insurance plans and the need for comprehensive coverage, the shortage of trained personnel in psychiatry, the basic fault of inadequate teaching programs within medical schools, and the great need for research in the field of mental disease. Specific recommendations to improve these deficiencies include making more funds available under the Hill-Burton Act in order to add 330,000 more beds to accelerate treatment facilities for short-term care in all hospitals. None of these ideas is new but the authority of this commission will help to break down resistance against psychiatry and to hasten complete integration.

How can psychiatric integration be accomplished? The following recommendations are offered as a sound basis for biological psychiatry:

1. Return to basic principles of medicine, with more research in application of anatomy, physiology, and pathology in order to understand brain disorders instead of relying upon vague, ethereal psychologic factors exclusively.

2. Discourage isolation of psychiatry from the general body of medicine and encourage all psychiatrists to remember they must be general doctors of medicine.

3. Treat early mental illness at the community level, preferably in general hospitals, in order to prevent chronicity and state hospital overcrowding.

4. Correct the basic fault of inadequate teaching in medical schools and also require experience in psychiatry in the intern's year.

5. Integrate psychiatric treatment, training, and research within general hospitals and develop closer working relationship with all specialties in general hospital setting.

6. Point out through The American Psychiatric Association and National Association for Mental Health the great needs and guide integration through all the above mentioned routes.

7. Work out economic plans to facilitate early treatment for the mentally ill, such as prepayment voluntary insurance, government subsidy to develop more treatment units, and the raising of funds through national health drives to train professional personnel.

8. Overcome resistance against accepting early psychiatric treatment through a program of public education, and break down discriminations within the general hospital against the mentally ill.

9. Adopt throughout the bodies of organized medicine the recommendations of the President's Commission on Health Needs of the Nation and thus improve psychiatric treatment, training, and research within general hospitals.

## BIBLIOGRAPHY

1. Kluver, Heinrich. Brain mechanisms and behavior with special reference to the rhinencephalon. The Lancet **72**: 567-77, Dec. 1952.

2. Huston, Paul E. The work of the committee on clinical psychology. Am. J. Psychiat. **109**: 791-92, Apr. 1953.

3. Psychiatry and Medical Education. The American Psychiatric Association, Washington, D. C., 1952.

4. Bennett, A. E., Hargrove, Eugene A. and Engle, Bernice. The Practice of Psychiatry in General Hospitals. New York: Grune & Stratton, 1953.

5. Ward, Clyde H. Some notes on psychiatric referrals in the University of Michigan hospital. Univ. Michigan Med. Bull. **18**: 176-84, June 1952.

6. Curran, Desmond. Psychiatry Ltd. J. Ment. Sc. **98**: 373-81, July 1952.

7. Luton, Frank H. The psychiatrist, his obligations and opportunities. J.A.M.A. **150**: 529-31, Oct. 11, 1952.

8. Muncie, Wendell and Billings, Edward G.: A survey of conditions of private psychiatric practice throughout the United States and Canada. Am. J. Psychiat. **108**: 171-72, Sept. 1951.

# A PLAN FOR REHABILITATING IMPROVED PSYCHOTIC PATIENTS [1]

FREDERICK SCHNADT, PH. D.,[2] FORT LYON, COLORADO

## INTRODUCTION AND GENERAL CONSIDERATIONS

Great advances have been made in the care and treatment of hospitalized mental patients in recent years, notably through shock treatment, subsequent or concurrent occupational and corrective therapies, and general emphasis on social and vocational rehabilitation. These methods of treatment, and others, have been markedly successful in bringing about improvement in behavior. In many instances, however, treatment procedures stop one essential step short of the final goal of restoring the patient to society as a useful and productive member. This paper outlines an intermediate step between hospitalization and discharge, proposing a new and vital type of unit, relatively self-sustaining financially, with unique treatment methods and goals.

Many patients, after entering a mental hospital with an active psychosis, have so benefited from newer treatment procedures that they are able within a few months or a year to achieve a privileged status, in which they accept responsibility for their own actions on hospital grounds, and do work of a productive nature. Numerous patients of this type have been capable of maintaining such status—which is a distinct advancement over confinement on a closed ward—for a year or more. During this time they have not become embroiled in any major difficulties, but in the cloistered hospital atmosphere have shown an ability to continue this limited type of adjustment, apparently for an indefinite period.

Under such conditions, patients are often discharged, or sent home on trial visits or similar conditional procedures in an attempt to establish outside adjustment. A large number fail to meet extramural demands, and return to the hospital. There, in familiar protective surroundings, a patient again may be able to achieve privileged status, involving personal responsibility.

Hospital administrators and personnel working with patients have seen this sequence repeated over and over. A patient is able to make adequate adjustment to the hospital situation, but the demands of the family or society are too great for even limited adjustment on the "outside." The reasons for such failure are too varied for discussion here, except to mention that frequently a return home involves subjection to conditions that were important in precipitation of the illness, and that occupational competition is often too demanding without some leavening agent between hospitalization and civilian employment.

For many types of handicapped persons there have been effected widespread and intensive procedures that have accomplished the final goal of restoring the individual as a productive member of society. Greatest attention in the United States has been given to the physically handicapped. Epileptics have had special consideration in some areas. Toward the typical improved psychotic, however, even if he has been in remission or near-remission for years, there is suspicion and skepticism.

The problem, and the necessity for bridging the gap between hospitalization and discharge, has been widely recognized. For example, Rennie, Burling, and Woodward (5, p. 4) in writing of the growing practice of keeping a patient on hospital rolls for a

[1] From the Veterans Administration Hospital, Fort Lyon, Colorado. Though the author is currently employed by the Veterans Administration, proposals made do not necessarily or particularly refer to or involve VA hospitals, except where explicitly stated, nor is it implied that the Veterans Administration is in the best position to take initial action on plans outlined here.

[2] The writer is indebted to a number of persons for contributions to this study. Dr. Kenneth R. Hammond, Department of Psychology, University of Colorado, was particularly helpful through stimulating criticism and encouragement. Prof. George Zinke, Department of Economics, University of Colorado, has strengthened belief in the socially economic plausibility of the plan. Mr. Frank R. Dietrich, Chief, Social Service, VAH, Fort Lyon, Colorado, and graduate students in the VA Clinical Psychology Program in training at Fort Lyon, have made timely suggestions and criticisms.

year or more after he has left the hospital, state:

> While the original purpose was to retain some control over the patient during a trial period and to simplify his readmission to the hospital if he was found not to be making an adjustment or if he had a relapse, the hospitals are beginning to recognize that treatment of the illness and the return of the patient to his former community are not enough and that not until he is reintegrated into the life of the community has the real purpose of the hospital been accomplished.

One may easily lose sight of the fact that not only do we have thousands of chronic patients for whom we are doing little constructively, but actually we are tacitly contributing to the development of chronicity in early psychotics by many present-day practices. Hildreth(3) has called attention to the need for a new therapeutic approach to continuous-treatment patients, rather than an extension of methods used in acute intensive treatment; in this relation he makes note not only of current chronic patients but of the "chronic-in-the-making" patient. By some present-day methods, in all sections of the country, we are probably unthinkingly contributing to the development of many chronic-patients-in-the-making.

Other than the humane, individual aspect, some students of the problem have considered the manpower loss occasioned by incomplete rehabilitation of chronic neuropsychiatric patients. Stringham(6), in prefatory remarks to a report discussing the success of extramural adjustment of 33 patients released on trial visit status after 12 years (average) of hospitalization, comments:

> At a time when our nation is in a declared state of national emergency, and we are faced with an ever-increasing shortage of manpower, it is very important for us to review all potential sources of manpower and make sure they are being utilized to the best possible advantage. One source that has hardly been touched lies in the thousands and thousands of chronic neuropsychiatric patients who are locked up within mental hospitals throughout the nation and for the most part cared for at taxpayers' expense.

It is not the thesis of this paper to deny, or in any way to disparage, the numerous attempts made by particular hospitals or agencies, or by assiduous medical personnel within institutions, to rehabilitate mental patients. Some countries have used colony plans (*e.g.,* Belgium) or foster home care successfully, notably Scotland, in promoting full rehabilitative measures. Foster home care in our country has been given increasing emphasis in many states(1, 4). Many industrial establishments have been highly cooperative in offering employment opportunities to improved mental patients.

Our thesis is that in our nation these procedures, commendable and successful as many are, are scattered, piecemeal, and dependent upon individual initiative. There is no long-term, cogent, comprehensive plan that includes an appreciable portion of patients who might be benefited. Our thesis holds that there can be a feasible, practicable solution, leading to further advancement for many patients who are now fixated at their present privileged level in hospitals, and who in long-term consideration could be self-supporting, or nearly so.

## An Intermediate Step—The Re-education Center

An intermediate step between hospitalization and discharge concerns what we might term a Re-education Center, Restoration Center, or Training Institute. The name as such has importance. The unit would not be called "hospital." It would not be a hospital.

The Re-education Center would have 2 main objectives, which in almost every aspect are interdependent. The first would be personality readjustment and the second occupational readjustment. Work for patients would involve a variety of occupations, with opportunities for socialization procedures offered to an extent not possible in a hospital setting, yet somewhat more protective than life on the "outside."

### THE BUSINESS PLANT

The core of the center would be a business establishment producing articles of simple structure, with emphasis on use of metals, but with items of leather, plastic, wood, etc., given lesser attention. Because of the widespread demand for material, gadgets, and paper work in our society, a considerable variety of work in mechanical and clerical fields could profitably be offered. In addition, farming activities might be carried on

in suitable areas. Other types of vocation could be offered according to local practicability, as well as patients' needs.

The question of what use and disposition would be made of products is of importance. Several methods might be considered; 3 will be mentioned here.

The simplest, and perhaps least valuable, would be to have products utilized by the Re-education Center, the patients themselves, and associated hospitals and agencies. It is probable, however, that one of the greatest values of a Re-education Center would be the realization by patients that they were producing articles needed by society, meeting standards set by society—in other words, that their work compared with that of men in extramural employment. Usage within a center or hospital setting only could well fail to carry this therapeutic goal. Furthermore, it might be difficult for a center to be operationally self-sufficient financially under such conditions.

A second method concerns a combination of a business plant working with rehabilitative personnel. The business establishment would be set up by a private company, for example one of our large electric, automobile, telephone, or refrigerator manufacturers. The company would establish a training center, and patients would be instructed by the company's work supervisors, who would have had or would be given training concerning mental illness. Products would be of a type usable by the company. Patients who successfully met standards might be given an opportunity in regular work elsewhere by the company; they would, of course, have the opportunity of accepting work with any other employer or of working for themselves, when ready to accept civilian employment. Patients in training would be paid by the company for work produced. Upon first consideration, this procedure might seem radical and unfeasible; however, when one considers that what we are attempting is the restoration of men to productive civilian employment, it is possible that a business establishment, from economic as well as humane values, might well consider such a plan.

A third method is to have products of patients compete on the open market with private industry. The hue and cry might immediately go up: "Impossible! This is government (state or federal) competition with private industry!" It is true that such competition would exist, but hardly on a scale that would financially affect business adversely. Again, the long-term goal is not offering competition to private industry, but developing men to a point where they can be returned to society as productive citizens. There is no real threat to society or to industry in this proposed third method. If one takes a narrow, short-term view, he may hold an antagonistic attitude; however, if human values and over-all benefit to society are given prime consideration, merits of the plan far outweigh disadvantages.

In any case, it is possible that sponsorship of a pilot project by a philanthropic organization or foundation would be the most feasible starting point. Such direction should be best able to protect rights of and advance a program for patients, and probably would be in the best position to coordinate governmental and industrial problems. Moreover, supervision through a foundation offers potential usage of the best features of all 3 plans.

There is a further possibility in establishing centers in connection with and as an adjunct to institutions of the domiciliary type, which might allow ease of initiating pilot projects without as extensive financial involvement, and which would conform more nearly with existing legislative regulations. Obvious disadvantages of a combination Re-education Center-Domiciliary plan, however, are that the freshness of approach and many stimulating features of proposals outlined would be greatly modified, and that direct or indirect association with domiciliary members would probably have a debilitating effect on center patients.

### MANAGEMENT AND DIRECTION

The management of the installation would be under the direction of persons well trained in psychiatry and psychology and an administrator who would have responsibility in business and industrial matters.

It is probable that a doctoral-level psychologist, with training and experience in clinical psychology, but with a background

also in vocational counseling, could most feasibly direct the psychological-occupational aspects of the center. A psychologist, rather than other psychiatrically-oriented person, is suggested because of the importance of determining proper job placement at the center —placement that considers not only interests and aptitudes, but also personality and capacity for adjustment. Garrett and Myers(2) have emphasized the importance of the clinical psychologist in rehabilitative procedures. Contacts with prospective employers, administration and interpretation of psychological tests, knowledge of applied psychology in industry—all of these factors would favor such direction in the hands of a clinical-vocational psychologist.

The business executive or manager would run the industrial phase of the center much like private industry. Products would be manufactured and packaged in much the same way as an industrial organization handles its business. Clerical work and other activities should be carried out in an efficient manner.

### STAFF

The number and variety of medical and psychiatric personnel required would be determined by size and needs of a particular installation. Some strictly medical service would be required, but of much less scope in personnel and equipment than for regular hospital care of a like number of patients. Several psychologists and psychiatric social workers would probably be needed, with limited ancillary personnel. It would be the responsibility of the staff to see that patients got attention and understanding in a permissive atmosphere, that goals be made realistic and possible to attain. Pertinent psychotherapeutic activities, on both a personal and an occupational level, would be given emphasis.

Supervisors of occupational training would be skilled men, with some knowledge of mental illness, as in well-staffed hospitals, and with capabilities as leaders or foremen. Unlike those in similar positions in hospitals, a supervisor would be expected to produce high-grade articles—comparable to industry. He would communicate to his workers the need for meeting quotas, maintaining standards, etc. In current hospital practices, emphasis is placed upon a patient's improvement; the patient wants to improve, but has no realistic progressive situation in which he can direct his occupational interests. It is probable that with schizophrenics in remission emphasis on the job-at-hand would have many healthy counterparts, offering tangible goals and satisfactions through step-by-step accomplishments.

### WORKING CONDITIONS

In general, conditions would be similar to private industry. This is an important feature. In psychiatric hospitals, work done is for "benefit of patients." Under most conditions a patient cannot be put under pressure to produce, and should not be. This situation, however, again tends to make the step to the outside too great. An ex-patient will not be coddled for long in private industry; he will either be an economic asset or be released, except in time of extreme labor shortage. Patients working in a Re-education Center should be given critical supervision and put under mild initial pressure increasing gradually to that of extramural working conditions—provided, of course, that the patient could accept such occupational demands, which is precisely what one would want to know.

It has been implied in the foregoing discussion that a patient, formerly badly maladjusted—to the extent of psychosis in most cases—will be subject, after a gradual apprentice period, to conditions of severe occupational pressure. This is true—but such pressure would not equal that placed upon a patient who enters the business world without understanding assistance from employers or co-workers; who struggles to get a job—in too many instances, any kind of a job—fresh from hospital discharge.

Patients would be paid a wage for work, with job promotion and advancement possibilities made clear. Organization and level of jobs, etc., should be made similar to private industry. Throughout, the goal should be kept in mind that the center is an intermediate step toward making an individual a producing member of society, for developing personal self-confidence parallel with occupa-

tional skill, for enhancing a socialized attitude.

It is probable that patients could be shown that the success or failure of a work project would be largely their own responsibility. Success would be indicated by a working-together, which is considered the antithesis of schizophrenia. Furthermore, it would be on a practical and an obvious basis. One who has worked with partially recovered schizophrenics realizes that many of them are not lacking in motivation or drive for group betterment or group goals, but rather are without available personal assets to initiate activity. The schizophrenic typically does not simply reject relationships with others, but is unable to go about forming interpersonal relationships. In addition, a patient's voluntary decision to go to a center and to actively participate in selection of occupation would be valuable rehabilitative measures.

### LIVING CONDITIONS

The most essential single objective of the center, of course, is rehabilitation, emphasizing stabilization of personality. The occupational aspect has been stressed here first because it is of such great importance in the early readjustment of discharged patients.

The location of a Re-education Center is open to conjecture. The setting suggested is a reasonably attractive physical environment, near or bordering upon a fair-sized town or small city of perhaps from 50,000 to 150,000 population. This size is suggested because it would allow for a considerable variety of facilities, without the rather obvious disadvantages of either a small town or a huge city. It should preferably be some distance from a mental hospital. Buildings and physical plant could be well of average construction. There would be little point in making the center luxurious, since it might offer temptations for dependent persons to linger.

Patients leaving a hospital (it is likely that some type of leave-of-absence or occupational trial visit would be more advisable than discharge) would be housed first at the Re-education Center much as on a privileged hospital ward, except that probably some individualization of rooms could be offered, rather than barracks-like housing (rooms for 4 to 6 persons might be preferable). Some recreational and library facilities should be available. Rules would be as few as possible, with ordinary regulations of extramural life followed when practicable.

Married men, following a successful adjustment period of about six months, would be allowed to bring their families to the nearby community—not the center—to live. This is important. Wives would be encouraged to participate in some center social activities. A trial period for family readjustment would thus be provided, during which a wife might well gain greater understanding of her husband's illness from observing other patients, talking with staff members, and participating in such activities as group psychotherapy. Meanwhile, with a patient living in town with his family, but working in the center business plant, staff members would have opportunity to assess a patient's readjustment capacity *before* relinquishing all supervision.

For single patients—and some of these have never held a job for more than several weeks at a time—the movement from center to community residence, with employment at the center, could be a valuable method of rehabilitation. Similar conditions as for a married patient, in which the single patient after a "proving" period would be allowed or encouraged to live in town, are indicated. Again, the center staff could offer guidance to the patient for a part of the day.

### PSYCHOTHERAPY

Various types of therapy, including nonformal psychotherapy, have been implied in numerous activities of the center. In addition, it is probable that group psychotherapy could be used to the best advantage. Everything is pointing to the reeducation of the patient and his restoration to society; if he is recovering in a true sense, he should gain and help others to gain understanding and strength through group association. Some individual psychotherapy might well be offered; moreover, there would be occupation-oriented, individual sessions that would also concern personal adjustment. In all probability, however, the group treatment, with its emphasis upon much needed socialization

features, offers greatest potentials for individual development.

The importance of psychotherapeutic treatment for the family of the patient can hardly be overemphasized. In many instances a patient's return to the emotional situation that contributed to his illness may re-initiate a psychotic process; this can often be modified or prevented through greater understanding of the patient by family members.

### AN EXAMPLE OF PROCEDURE

Though details have necessarily been considered in a number of instances, the foregoing description of an intermediate step toward rehabilitation of mental patients has been generally sketchy. Much of the outline would have to be filled in, and different areas would have varied problems. In some instances several states, or a given geographical region, might have 1 Re-education Center serving a number of hospitals; in others, 1 or 2 large hospitals might well supply 1 such center.

As an example, the situation might work something like this:

Patient Tom Smith has been on full privilege status at Neuropsychiatric Hospital A for 6 months; prior to that time he had been generally improving, as judged by hospital staff, and had been on partial privileges for 3 months following treatment for a psychotic episode. He is sent on vocational trial-visit status to Reeducation Center B, where he is approached as a person with a future, given a series of vocational tests, and placed in a job fitting him. Tom does not do well at this job, and is given another. There he shows promise, and after 6 months of successful living and working at the center, is allowed to bring his wife and 2 children to the community. Following a period of difficult adjustment for Tom and his wife, the family relations become improved, aided by psychotherapeutic work by the center staff with both husband and wife. After a 6-month period, Tom is recommended for a job, and he and his family move to that location. (It should be noted that recommendation came from the Re-education Center, in part a business concern where Smith had been working for a year; this is far different from a mental hospital discharge).

Smith's case, of course, would be relatively an ideal one. On the other hand, if he had failed to adjust at the center, the way would have been left open for his return to Hospital A or some other associated hospital. If after going on the outside, he had failed to adjust, he could be returned either to Center B or Hospital A, depending on severity of maladjustment; if unable to hold a job because of lack of skills or minor instability, to the center; if a psychotic episode appeared imminent, to the hospital. From this point he might again be able to improve sufficiently to reach the center.

Other individuals might be able to get as far as the center, but would not show enough promise to be given a chance in civilian work. Even this move, which makes for relative self-maintenance, is a step above the hospital, for which the taxpayer foots all the bill. Also it makes room, under overcrowded conditions, for a second person to get inpatient attention.

### A SPECIFIC EXAMPLE OF NEED FOR A REEDUCATION CENTER

The Fort Lyon, Colorado, Veterans Administration Hospital has approximately 750 neuropsychiatric patients, most of whom are diagnosed as psychotic. About 150 are on full or partial privilege status, with the psychosis in at least partial remission. One hundred of these, who are given fullest privileges, are housed in a separate building. They are responsible for reporting to specific job assignments (details), and for maintaining behavior appropriate in social relations with fellow patients, supervisors, and hospital personnel generally. Many of these men have held this type of privilege for 2 years or more and some for a considerably longer period.

Of this group, probably ⅔ could be moved immediately to a Reeducation Center of the type described. Perhaps half of these (a conservative estimate) might be given a trial on the outside after showing improvement at the center. As matters now stand, these patients are held where they are for 2 principal reasons: First, parents or relatives do not want them at home, and second, hospital authorities are loathe to send patients who have required extended hospitalization out into the world without some means of emotional and financial support. Under such conditions, a man may remain for years in a medical setting offering costly specialized care no longer needed by him; meanwhile, the patient loses hope of ever advancing be-

yond a privileged status in a mental hospital, though he believes—correctly—that he has improved markedly. It is difficult for ward doctors and administrators to convince such patients that they should remain in a hospital; yet without some means of outside support, the risk in discharge is high. The Reeducation Center would be a solution for many such patients.

Not all neuropsychiatric hospitals have a like situation regarding privileged patients, but most, if not all, have a number of chronic patients whose illness has not been severe for years—who are withdrawn rather than violent, unsociable rather than antisocial. A high percentage might well be benefited; attention, change of scene, and promise of tangible gain sometimes evoke surprising results even in long-term chronic illnesses.

### ADVANTAGES AND DISADVANTAGES OF THE RE-EDUCATION CENTER

An immediate concern for one considering taking the responsibility for an additional, different type of treatment center for mental patients, is naturally the matter of cost. Initially, for housing, equipment, and staff the outlay would be large, but not as much as for a new mental hospital which might have to be constructed instead. Following the original investment, the plan would be far less expensive for individual patient-treatment than would hospitalization. In fact, as outlined here, most if not all running expenses would be covered by the business-type operation of the industrial plant.

There are a number of factors that are not necessarily disadvantages but are problems that would require working out in the kind of project discussed here. These problems include legal aspects of hospitalization and discharge; labor relations, involving wages and working conditions; social pressures and prejudices that today still surround the mental patient; with veterans, the attitudes of organizations for service men; and various other considerations that are not within the scope of this paper.

As another possible disadvantage, one might question whether Re-education Centers could be adequately staffed, with current shortages of psychiatrists, psychologists, social workers, and ancillary personnel. It seems, however, that with greater emphasis upon occupational effort, a greater number of improved patients could be more adequately cared for with fewer strictly medical workers than under any currently existing treatment plan.

Some of the disadvantages, then, are more apparent than real. In contrast are the advantages, of which only the more obvious will be listed. These are:

1. A new method of leaving the hospital is offered to the patient. There is greater progress possible before discharge, and much of that progress can be seen and judged by the patient himself. A ladder one can climb exists where there was none before, and concrete, perceptible advancement can be made upon it.

2. In the new setting, the patient may pay his way—at first in part, then in full upon leaving a center.

3. For married men, opportunity for resumption of family life under favorable conditions is available.

4. General possibilities for socialization of patients are greater than at any existing type of installation, including mental hygiene clinics, which ordinarily prefer not to treat psychotics. Moreover, this type of group education is not usually offered in existing institutions.

5. The old stigma of going directly to a job from a mental institution is obliterated. This is an important point. The stigma of hospitalization is not entirely removed, of course; but records of a successful work period follow hospitalization and precede application for civilian employment. The opportunity to get a recommendation by supervisors and administrators who are primarily businessmen or industrial foremen is important; such support is rarely possible under current treatment of mental patients.

6. Patients can be placed under pressure *before* they enter extramural competition. Other than obvious advantages here, are the factors that in a Reeducation Center such pressure can be controlled, and that competitors are fellow patients.

7. Much of the chronicity in mental patients can be prevented; some can be eliminated, or ameliorated. The Reeducation Center would not only allow the advance-

ment of patients through a new treatment level, but would serve as a proving ground before commitments were revoked; and would provide less risk by administrators than discharge usually involves.

8. Treatment cost would be reduced for those patients transferred from hospital to center.

9. Movement out of hospital would be accelerated, eventually influencing favorably the rate of discharge. This point is particularly significant in that the movement would take place among patients who otherwise would probably remain where they are.

The 9 advantages do not exhaust the list. Others can well be added, and in particular situations, stronger arguments than these could be given. All in all, the intermediate step of a Re-education Center would seem to offer to some stymied or overlooked mental patients a chance to prove to themselves and others, mostly by their own initiative, that they can make a contribution to society outside the boundaries of a hospital.

If what has been proposed should sound impracticable or radical, one might consider the reaction of a hospital superintendent of 1900 visiting a present-day modern neuropsychiatric hospital, with patients working on weaving, ceramics, etc., instead of sitting idly on wards. The present plan is only a short, but vital, step beyond, in which the patient is offered an opportunity for adjustment under realistic conditions.

The proposals outlined are flexible. Any eventual projects resulting from ideas discussed here may differ greatly from specific suggestions of this paper. The important factor is not how much of the plan is accepted, but rather that suitable mental patients be given a favorable opportunity to return as useful and productive members of society.

## BIBLIOGRAPHY

1. Crutcher, Hester B. Foster Home Care for Mental Patients. The Commonwealth Fund, New York, 1944.

2. Garrett, J. F., and Myers, J. S. Clinical psychology in the rehabilitation process. J. Rehabil., 17: 2, Mar.-Apr., 1951.

3. Hildreth, H. M. Research approaches to psychotherapy. Paper read at Fourth Annual Neuropsychiat. Mtg., Little Rock, Ark., Feb. 1952.

4. Pollock, H. M. A brief history of family care of mental patients in America. Am. J. Psychiat., 102: 351, Nov. 1945.

5. Rennie, T. A. C., Burling, T., and Woodward, L. E. Vocational Rehabilitation of Psychiatric Patients. The Commonwealth Fund, New York, 1950.

6. Stringham, J. A. Rehabilitating chronic neuropsychiatric patients. Am. J. Psychiat., 108: 924, June 1952.

# THE IMPORTANCE OF CONSTITUTION IN PSYCHIATRY [1]

G. LANGFELDT,[2] M.D., Oslo, Norway

In a country where behaviorism and psychodynamic processes seem to be completely overwhelming in psychiatric discussions, a psychiatrist who tries to call attention to the much disputed conception of *constitution* runs the risk of being considered as old-fashioned. Nevertheless, a psychiatrist who, like myself, in practice is faced daily with the many different types of personalities and the neurotic and psychotic reactions related to them, cannot escape noticing the uniformity of many of these reactions. Another clinical experience is that when you are familiar with the character traits of some groups of patients, the neurotic or psychotic reactions will frequently be easily understood, without any deeper analysis of the symptom formation being necessary. This again is related to the experience that most of the reactions met with in such individuals can be explained either as simple exaggeration of pre-existing character traits or on the basis of introversion or projection tendencies in sensitive individuals. The fact that clinically we are able to state that neurotic and psychotic reactions of the same contents occur in individuals characterized by quite special traits also points strongly to the importance of the reactions of the constant psychobiological outfit of these personalities. In fact, the reactions in question, which in Scandinavia are usually termed constitutional reactions, are very common, but frequently not recognized as such, being misinterpreted as, among other things, schizophrenic reactions. This is the reason why I think a subtle study of all the types of constitution disposing to such reactive psychoses is one of the most important tasks of clinical psychiatry. In the *Diagnostic and Statistical Manual of Mental Disorders* recently approved by The American Psychiatric Association, there are, except for the paranoia and paranoid reactions, no groups that cover the many other constitutional psychoses. My experience during the time I have been in this country also has strengthened my impression that most of these psychoses are diagnosed as schizophrenic, and this again, of course, is very unfortunate for the practical evaluation of the prognosis in these states as well as for the indications of therapy and for scientific researches on the etiology and pathogenesis of schizophrenia.

Before entering into the question of the practical clinical importance of constitution in psychiatry, however, we must try to clear up the conception of constitution. While formerly many researchers restricted this conception to the inborn or inherited outfit of an individual, or to the psychobiological unit brought about by the interaction of inherited tendencies and the influences from the surroundings during the first years of childhood, most psychiatrists now probably agree that constitution is not a static apparatus, but a psychobiological one in steady daily interaction with internal and external physical and psychical stimuli. What we should call constitution, then, is the total psychobiological outfit of a personality that because of inherited and external factors, has been stabilized to such a degree that it can be changed only by severe psychic or physical influences.

If this definition is agreed upon, it should also postulate that the development of the constitutional type of an individual is dependent ultimately on specific genes and on the so-called genotypic milieu including all other nonspecific genes. Next there is the question of environmental influences and of the psychodynamic reactions of the individual to special experiences. Consequently the development of the constitution is very complicated, varying from individual to individual. All the same, clinically we meet with personality types that display so many common traits that some common origin must be assumed. As the environmental influences vary to a high degree from individual to individual, the common factors must be sought in the specific or nonspecific genes of the individual, manifesting themselves in the individual anatomy, physiology and chemistry of

[1] Read in the series on "Modern Psychiatric Concepts," Veterans Hospital, Downey, Ill., April 1, 1953.

[2] Professor of Psychiatry at the University of Oslo, Norway.

the human body. This, of course, does not mean that the individuals in question are born with hereditary traits that cannot be changed after birth. On the contrary, our definition of constitution implies that all hereditary traits from the time of conception are subject to change, in interaction with the whole genotypic milieu during pregnancy, and with the surroundings after birth. However, when this development results in personality types with common traits and with a disposition to common reactions, this cannot, in my opinion, mean anything but that quite specific hereditary traits have been so established that they characterize the individual during the whole development. There is, in other words, a limit to the changing of character traits that cannot be exceeded.

Many and varied suggestions have appeared aiming at a differentiation of typical personality types. Most of them are based on direct description of the dominant characteristics, for example, the different psychopath types described by Gruhle, Kurt Schneider, and G. Bleuler, in almost the same terms, such as the depressive, the sensitive, the passive, or the aggressive psychopath. Another kind of description is the *introverted* and *extroverted* personalities of Jung, or Jaensch's *integrated* or *disintegrated* personalities. There has also been suggested a description according to endocrine types or according to fundamental interests. Thus Spranger proposed a differentiation between esthetic, economic, political, social, and theoretical types of personality. Another method differentiates psychodynamic typologies aiming at a deeper understanding of the ethical, moral, and religious sides of the personality and whether the personality as such is characterized by special mechanisms of behavior, dissociation, compensation, rationalization, identification, or sublimation; in other words, whether the personality has the capacity of using the normal dynamics for solving a conflict. If this is not the case the dynamic exploration should indicate whether the means of repression, introversion, regression or the projection and defense mechanisms are resorted to. Here we meet with the many structural-analytical typologies of Adler, Ewald, Freud, Jung and Kretschmer. All these typologies have contributed to a better understanding of the psychodynamic processes in neurotic as well as psychopathic individuals, even if the theoretical considerations sometimes are somewhat speculative and too one-sided. It is not my intention to take up in detail the delicate question, still a matter of discussion, of whether the different personality types can be explained only as a result of the environmental influences and the reaction of the individual to the different experiences, or if hereditary dispositions must be presumed. It is, however, necessary to point to some researches and clinical experiences that may help clarify the problem.

As to the development of the normal personality, it goes without saying that the individual is born with quite specific dispositions inherited from both parents through specific and nonspecific genes. From the first day of life, however, these dispositions are supposed to be subject to environmental influences and the personality type is, as previously discussed, a result of this interaction. It is, however, quite evident that in the single individual there is a limit to the molding and development of the personality, and this limit must be conditioned by the capacity of the inborn abilities on the one side and the power and nature of the environmental influences on the other. As to the question of the intellectual life, it seems indisputable that the hereditary equipment may be so poor that even the most fortunate surroundings cannot change it. The many characterologic studies also seem to agree that as to the emotional life and the life of will and drives the influence of surroundings and experiences is also, to quite a large extent, limited. With these facts in mind there should be no wonder that in psychopathology we frequently meet with anomalies in the field of the intellectual, emotional and will-life that can scarcely be explained without assuming that special character traits have been developed or underdeveloped to a pathological degree. From whatever point of view the so-called abnormal personalities have been studied and described, what came out was disturbances of intellect, emotion, will, and drives. In fact, corresponding to this experience most of the many psychopathic personality types described can be grouped as paranoid, emotionally unstable, or respectively, as passive or aggressive personalities. Clinical experi-

ence favors the assumption that likewise a sensitive disposition and compulsive trends can be so fixed that they characterize the individual during his whole life. In addition, heredity investigations have stated that in the surroundings of manic-depressive psychoses and schizophrenia we meet with, respectively, the cycloid and the schizoid type of psychopathy.

It may perhaps be argued that the importance of a hereditary disposition to the pathological constitutional types characterized by intellectual, emotional, and will disturbances cannot be admitted as long as there are no heredity investigations that prove the existence of the same kind of disturbance in the direct ascending or descending family. With modern concepts of heredity, however, this is no argument, inasmuch as the possibility exists that a specific hereditary disposition may be changed during pregnancy and after birth by influences from nonspecific, genotypic milieu and from the environment.

The third point that seems to favor the existence of quite typical constitutional types is that some well-defined personality types react to different kinds of stimuli in exactly the same way. A sensitive individual with a tendency toward introversion may react with either depression, compulsive trends, or conversion symptoms to several different kinds of stimuli, while an individual characterized by a tendency toward projection regularly reacts with suspiciousness or paranoid symptoms. We also see that cycloid psychopaths may react with a hypomanic attack to psychic influences as well as to intoxications of different kinds. These clinical facts cannot, in my opinion, be explained except by assuming that the constitutional type in question is the most important factor in the production of the pathological reactions.

So we see that experiences from normal characterology, from heredity investigations, and from clinical psychiatry strongly support the assumption of the existence of quite typical pathological characters, disposing to special pathological reaction types. This, of course, is nothing new, it is only a statement of facts that in the present state of psychiatry seem increasingly to be forgotten.

However, my purpose is to emphasize the great practical importance that the recognition of the constitutional types and the constitutional reactions has in daily clinical work. But first it will be necessary to discuss the question of whether there is any principal difference between a neurotic character and a psychopath. Theoretically it may be maintained that there is no such principal difference inasmuch as it must be supposed that a hereditary disposition is present in both of these abnormal character types. Even Freud assumed a congenital disposition to be essential in the neurotic character. Most psychoanalysts will probably also maintain that in the psychodynamics taking place there is no difference between a neurotic and a psychopathic character type. From a clinical point of view, however, it must be stressed that there is evidence from abundant research into hereditary conditions that, at any rate as far as the cycloid and schizoid psychopathies are concerned, a specific hereditary disposition exists; that there is a principal difference in the means by which the neurotic character and a psychopath try to solve a conflict, and also in the behavior and symptom formations; and that most clinically experienced psychiatrists and psychoanalysts agree that there is also a definite difference between the 2 types of character anomalies in respect of the possibilities of their benefiting from the different therapies. Possibly it will be of interest to consider more closely the difference in the psychodynamic processes supposed to take place in the neurotic and in the psychopathic character. In the study of a large number of patients in a psychiatric hospital and a number of incarcerated criminals, the difference between the 2 groups becomes quite obvious; Kurt Schneider characterizes the one kind of person as himself suffering from the psychic abnormalities, and the other kind as one by which society is suffering. To be sure, here as anywhere else in psychiatry we meet with all transitional states, but if one wants to study the principal difference between 2 groups of symptoms or characters he must keep to clear-cut cases, and if we do that, it is an easy matter to point to a large number of patients, frequently met with in private practice and psychiatric hospitals, whose disabilities can best be explained by saying that these are individuals extremely sensitive to

stimuli hurting them on sensitive points in the mind. At the same time they have a disposition, presumably hereditary, to introvert the uncomfortable emotional feeling of guilt and shame arising frequently from insignificant internal conflicts. On the other hand, we also meet with individuals who react to similar stimuli by immediately projecting the feeling of guilt on the surroundings. In this way these individuals escape the uncomfortable feeling of guilt, replacing it by ideas of injustice from the surroundings, by overcompensation, or by ideas of persecution and so on. We may also have the opportunity of studying these individuals in psychiatric hospitals as they are specially disposed to constitutional psychoses, but otherwise these abnormal personalities are most frequently met with in jails. The first kind of individual whom, for convenience, I shall call the *introjection* type have been shown in clinical studies to be characterized, on the whole, by quite another clinical picture and also quite another susceptibility to treatment, than that of the other type, whom I shall call the *projection* or *characterogenic* type. Quite generally it can be said that the symptomatology in the introjection type is caused by the psychodynamic processes resulting from the introjection and retention of the conflict. The symptoms may be depression, inhibitory reactions, self-reference tendencies, or there may be psychodynamically more complicated symptomatologies as met with in compulsion neuroses. In the other type, the projection and characterogenic type, the symptomatology can, as a rule, be easily understood as exaggeration of normal character traits, without any deeper analysis being necessary.

From practical clinical points of view I think the first mentioned states, with the introjection tendencies, correspond to the psychoneuroses, while the states characterized by a projection tendency or an exaggeration of character traits should correspond mostly to the group of psychopathies. Even if the theoretical presumption that the psychopaths should be more hereditarily conditioned than the neurotic states cannot be proved for all the types regularly included in the psychopathies, the evident difference as to symptom formation, course, and susceptibility of treatment calls for a nomenclature suitable for the differentiation. There is no need to go further in the symptomatology of the neurotic character and the neurotic reactions. I shall only point to some special conditions that may seem to be somewhat confusing when looked upon according to what has been presented here. As the most typical constitutional types—psychopathies if you wish—met with in clinical psychiatry, I shall consider the sensitive, the hysterical, the compulsive, the paranoic and paranoid types. The hypersensitive constitution is probably the abnormal constitution that plays the most important role in psychiatry as the basis of neurotic as well as some psychopathic and psychotic reactions. It is easy to admit that all reactions associated with psychogenic depressions, self-reference, and inhibitory reactions are brought about by a varying degree of hypersensitiveness. Also the different symptom formations in the tendency toward compulsive thinking, in the phobias and compulsions, are closely associated with the sensitivity of mind.

In my book, *The Hypersensitive Mind*[8] I have also demonstrated, by the help of some typical cases, the importance of a hypersensitive mind in the melancholic states of manic-depressive psychoses, although here we are dealing with quite other psychodynamic processes than those involved in the psychoneuroses. Also, in initial cases of schizophrenia and more frequently in the schizophrenia-like psychoses, a hypersensitive disposition will frequently display itself in the symptomatology. It is an interesting fact that in all these cases, in the neurotic as well as the psychotic cases, the symptom formation can be best explained by assuming that conflicts of different kinds cannot be solved by one of the usual ways. As a consequence the conflict remains causing depression and self-reference neuroses and psychoses or a means of seeming solution is reached, as is the case in the compulsion and conversion neuroses. So we see that the sensitive constitution plays an important role in the reactions described—a fact that is not always given sufficient attention in the different kinds of psychotherapy.

Now, as to the other pathological condi-

[8] Langfeldt, G. The Hypersensitive Mind. E. Munksgaard, Copenhagen, 1952.

tions in which the constitution seems to play an important role, we obviously are dealing with quite another basis for the symptom-formation and other psychodynamic processes than that met with in the cases characterized as psychoneuroses. In this paper I shall restrict the discussion to the question of the importance of constitution in the cyclothymic and schizoid, the hysterical, the compulsive, the paranoic, and paranoid character types.

The cyclothymic and schizothymic characters, and the corresponding cycloid and schizoid psychopathies, are the constitutional types most generally accepted as being of hereditary origin. As is well-known from the abundant research into the heredity of manic-depressive and schizophrenic psychoses, between 30 and 35% of psychopathy is found in the family surroundings of these psychoses, most of which belongs to the cycloid and the schizoid type. The character traits present in these psychopaths are well-known; I find it superfluous here to cite them. I shall only mention that these character traits are such that from the psychological point of view it seems natural to look upon them as being derived from dispositions correlated with the manic-depressive and the schizophrenic psychoses.

For our topic now, it is of the greatest interest that the abnormal constitutions mentioned, the cycloid and schizoid personalities, play an important role in clinical psychiatry and in criminology. These character types seem in themselves to be disposed toward reactive psychoses, which may develop without demonstrable external influences. In addition, these personalities seem to react more easily than normal individuals to psychogenic as well as to physical traumata. Further, the cycloid as well as the schizoid personalities are, as mentioned, frequently met with in forensic psychiatry, where as a rule it is an easy matter to demonstrate the relations between criminal acts and abnormal character traits. As an example I may mention the relations between a cycloid personality, pseudologia and falsifications, or the relations between a psychically anesthetic and emotionally flattened, schizoid person and a murderer.

As to the existence of a hysterical character opinions are varied. While some psychiatrists accept only the existence of hysterical reactions including hysterical neuroses as well as hysterical psychoses, others maintain the existence of a constitutionally conditioned hysterical character.

I think the normal characterology as well as clinical experience speak strongly in favor of the existence of a relatively well-characterized constitutional type that predisposes to the symptoms regularly met with in the hysterical reactions. On the other hand reactions of soldiers in war and people influenced by mass-suggestion seem to prove that hysterical reactions are very common during states of mind in which the higher control of the psychomotor functions is lost. This means that hysterical reactions may occur also in people who are not characterized by a hysterical constitution; it is, however, of interest that relatively frequently one meets individuals characterized by a typical syndrome of purposiveness. Without going into detail I may mention that there are especially 3 series of syndromes that are most commonly met with. The first is the formation of purposive reactions, serving purposes of one or another individual gain. Freud, who was especially interested in studying the ways in which the hysterical personalities tried to solve their conflicts, gave this purpurposiveness the name *Flucht in die Krankheit* (flight into illness). By this term he indicated that the hysterical individual, for the purpose of getting rid of his painful conflict between drives and the moral standard (super-ego), converts the primitive drive-impulses into physical and psychic symptoms. Adler, in describing the "attitude to life" that many individuals display in order to overcompensate the feeling of inferiority, also pointed to the purposiveness in this attitude. Such purposive reactions are very common in many children, and are used as a way to escape from unpleasant duties. In hysterical individuals this disposition to purposive reactions is a very central symptom, characterizing the whole behavior of the individual. One of the most marked of these purposive reactions in hystericals is a behavior likely to concentrate the attention of the surroundings on the individual, and if the patient does not succeed in this, he or she has

other means to achieve the purpose, most frequently through conversion symptoms.

A second principal trait in the hysterical character, therefore, is inability to solve emotional conflicts in a normal way, and the attempt to solve them by the formation of complexes, which are then repressed from the conscious level. These complexes, again, are regularly agencies in hysterical symptom formation, of which the conversion into physical symptoms is the most common and typical.

The third hysterical trait is the increased emotional lability and impressionability, associated with increased suggestibility. A dominant trait in the hysterics is a display of vivid affectivity, expressing itself in outbursts of temper as a response to insignificant stimuli and in psychomotor outbreaks like gesticulations and mimicry. This vivid affectivity and increased psychomotor activity also contribute to the increased facility of expression. It is superflous to mention examples of these tendencies in hysterical individuals, common as they are. The 3 types of tendencies described are regularly present as central traits in all typical hysterical characters. Probably, therefore, these traits are predominantly based on hereditary dispositions, forming the constitutional basis on which the complex symptom formation in hysteria develops. I am however of the opinion, more closely developed in my book already referred to, that educational methods are very important in influencing the development of the hysterical characters. Even if, as is probably the case, the hysterical character in adult age is biologically fixed and changeable only with difficulty, if at all, we should not be pessimistic as to the possibilities of preventing this biological fixation if a psychologically correct education takes place in early childhood.

The next character type to discuss is the compulsive character, about which there can probably be no doubt that it is constitutionally conditioned. In psychiatric textbooks one will, as a rule, find the term compulsive neuroses covering all the disorders characterized by compulsive thinking, phobias, and compulsions. Some authors have a special chapter on the so-called neurotic-compulsive character. Generally this type is supposed to be predominantly of psychogenic origin. Many outstanding psychiatrists, like Janet, Freud, Luxemburger, and Schneider, have been much concerned with the pathogenesis of this type, even if the theoretical conceptions have varied greatly While Schneider and Janet point to special constitutional dispositions underlying this character type, and while Luxemburger has demonstrated the hereditary relation to schizophrenia, Freud is of the opinion that there are quite special psychodynamic processes that result in what he calls the anal-erotic type of character. I shall not here take any decisive standpoint to the different hypotheses on the question of the pathogenesis of the compulsive character. To our topic the only important thing is that outstanding psychiatrists with greatly varying concepts agree that the compulsive character type exists and plays an important role in clinical psychiatry. In the way we have here defined constitution, the question of how much of it is hereditarily conditioned and how much is conditioned in experiences and special psychodynamic processes plays no role. The important thing is that we have to do with a character type with a very typical constellation of symptoms, frequently met with in the normal population, but also frequently disposing to the development of abnormal compulsive characters and compulsion neuroses. Further I wish to stress the fact that many of the compulsion neuroses developed in compulsive characters are only to be looked upon as exaggerations of the character traits in question. Consequently in many cases it is of no use to analyze the meaning of the presenting symptoms by tracing them back to childhood. For example, in the case of a very sensitive individual who dreads the uncomfortable feeling of shame from making mistakes, it should be superfluous to analyze why in his daily life he secures himself against such mistakes by always doing things 2 or more times before making a decision, or why he secures himself by other methods. Neither is it surprising that a very anxious and sensitive individual hesitates to cross a traffic-thronged street. The situation in all the character types discussed is the same, viz., that when you are acquainted with the central character traits in an individual, many of the symptom formations in normal, as well as in pathological,

conditions are as a rule easily explainable without any deeper analysis. We arrive therefore at the conclusion that the compulsive character type is constitutionally fixed, and predisposes to the development of all the different types of compulsive neuroses.

The last types of constitutions to be discussed are those met with in paranoic and paranoid psychopaths. To avoid misunderstanding it is necessary to make a few remarks as to the nomenclature. Even though in the pathogenesis and symptomatologies there is a principal difference between paranoic and paranoid states, in most papers only the word paranoid is used. While in The American Psychiatric Association manual there is differentiation between paranoia and paranoid states, in the description of the personality disturbances in the manual only the term paranoid personality is mentioned. In Scandinavia we are accustomed to characterize the personality in individuals suffering from true paranoia as paranoic, while other psychopaths displaying a tendency toward projection with suspiciousness, envy, extreme jealousy, and stubbornness are called paranoid psychopaths. The principal difference as to pathogenesis of these abnormal character types is evident. In the paranoic states the pathogenesis is best explained by Kretschmer in his *Sensitive Beziehungswahn*. We are here considering sensitive individuals who, due to a special type of temperament, which Wimmer called paranoigenic temperament, are easily hurt on special central points in their personality, like the feeling of honor, justice, religion, and sexual feelings. These character traits have, as a rule, been present from youth and have predisposed to the development of the psychosis called paranoia, but they also predispose to more temporary paranoic reactions. The central psychodynamic process that may result in a paranoia or a paranoic psychopath seems to be the projection tendency, which characterizes these sensitive individuals, as distinguished from the neurotic individuals who tend to introvert the feelings associated with the sensitive reactions. Next, the paranoic reactions are characterized by delusions which, by the help of falsifications and a selective memory become more and more systematised comprehending all experiences that support the leading idea of being persecuted, of being loved by persons of high station, of having been subjected to the gravest injustice or of having received divine inspiration convincing the patient that he is a prophet, and so on.

It is also characteristic that these paranoic psychopaths as a rule continue for decades to display these delusions without any marked deterioration. In the paranoid psychopaths we meet with quite other personalities and symptom formations. These individuals also are, as a rule, characterized by stubbornness and suspiciousness, the tendency toward jealousy, but they do not have the prepsychotic temperament characterizing the paranoic individuals called paranoigenic. Here we do not meet with the ambitiousness so characteristic of the latter, and neither do we find the systematised building-up of a system of delusions. The delusions in the paranoid psychopath are more varying and seem to be more transient. This paranoid syndrome is not met with only in the paranoid psychopath, it is probably the most common syndrome in clinical psychiatry. We may find a paranoid syndrome frequently initiating a general paresis, or cerebral arteriosclerosis or in toxic reaction types. It is also dominant in the different types of paranoid schizophrenia. It is important to remember that, on the other hand, the typical paranoic syndrome is not found in states other than true paranoia and in the paranoic psychopaths. It is never found in organic brain diseases or in schizophrenia. I have emphasized the differentiation between a paranoic and a paranoid syndrome because the nomenclature in the U. S. A. does not seem always to be quite clear on this point. I find it, however, for theoretical as well as practical clinical reasons, to be of the greatest importance to differentiate between them. The paranoic as well as the paranoid personalities must, however, according to my opinion, both be looked upon as conditioned in an abnormal constitution, predisposing to very different reactions.

## Summary

Heredity investigations, normal characterology, and clinical experience speak strongly in favor of the existence of well defined types of constitution that play an important

role in pathology and criminology. By constitution is here meant the total psychobiological outfit of an individual that is so fixed that it can scarcely be changed except by long-lasting psychical or physical influences.

The constitutional types most frequently met with in clinical psychiatry are the sensitive, the cyclothymic and schizoid, the hysterical, the compulsive, and the paranoic and paranoid constitutions. The author is personally of the opinion that the fundamental and central traits in all these character types are of hereditary origin and does not think that psychotherapy, even at an early stage, will have any great influence in changing these personalities, except perhaps in the hysterical and possibly the paranoic types. A common trait in all these constitutional types is the disposition to many neurotic as well as psychotic reactions, which can be understood either as exaggeration of the character traits in question or by assumption of the relatively simple psychodynamic processes of introjection, conversion, or projection. During life many psychoneurotic mechanisms may take place in these individuals and this is the reason that many of them may profit from psychotherapy.

The sensitive constitution is supposed by the author to be the basis for development of the simple depressive reactions, self-reference reactions, and inhibition reactions, as well as for several of the compulsive neuroses, that are not developed on the basis of a compulsive character.

In addition the author assumes that most of the paranoic reactions are also due to a hypersensitive constitution. While the symptoms in the sensitive neuroses are best explained by assuming a tendency toward introjection, in the paranoics we have to do with sensitive individuals with, probably, an inborn tendency toward projection. As to the relation between the hysterical character and the symptom formations in the hysterical neuroses, these are, as is generally agreed, best explained by the assumption of a tendency to convert the conflict into bodily symptoms. And as to the symptoms in the cycloid and schizoid characters, these are best explained as direct hereditary character traits, while the symptom formation in the reactive psychoses is best explained as an exaggeration of the character traits.

The author believes it is tremendously important to try to diagnose and differentiate the constitutional types. This enables one to understand the personality itself as well as the pathological reactions without any deeper analysis being necessary. Study of the constitutional types gives the best clues to the question of the prognosis of the various reactions; likewise, a knowledge of the constitutional type behind the reactions helps to safeguard against false diagnosis, especially of schizophrenia.

# LEVEL OF ACHIEVEMENT AFTER LOBOTOMY

## A Study of One Thousand Cases [1]

WALTER FREEMAN, M.D.,[2] Ph.D., Washington, D. C.

This study deals with the levels of social effectiveness or achievement after lobotomy. Some of the questions concerning the validity of lobotomy in the treatment of mental disorders can thus be answered. If it is found, for instance, that lobotomy results in an inert, robot-like type of individual without imagination, without social graces, without any sparkle to the personality—then lobotomy should be reserved for those patients whose sufferings are beyond human endurance, even as a method of "partial euthanasia," described in that fashion by Rioch(1). If, on the other hand, it is discovered from a long-range follow-up of lobotomized patients that relapses are so frequent that by the end of 5 years more than half of the patients released from the hospitals are again back in their accustomed surroundings, then the operation can be termed palliative, to be used with discretion to bring relief from suffering, but without expectation of return to effective social existence. What this study actually shows is a gratifying and sustained improvement after lobotomy.

Since most of the previous follow-up studies have been performed primarily on patients remaining in hospital under observation(2), the tracing of patients who have been discharged from the hospital and returned to the community becomes a proper field of investigation. Such studies have been carried out by Partridge in England(3), but nowhere else to the same extent. The present study aims at delineating the lobotomized patient after stabilization. It is not a complete picture because the level of social achievement seems to be rising even 5 years after operation. Furthermore, while there are only 80 patients in the extreme end of the study (10-16 years), nevertheless, 60% of them are functioning almost as well as they did before the onset of the mental illness. When the attrition due to aging and changes in fortune of families is considered, this is a remarkably high figure.

[1] Read at the 109th annual meeting of The American Psychiatric Association, Los Angeles, Calif., May 4-8, 1953.

[2] From the Department of Neurology and Neurological Surgery, George Washington University.

### MATERIAL AND METHODS

The Freeman-Watts prefrontal lobotomy patients, 622 in number, were followed for at least 2 years and many of them for more than 10 years or until death. The other main group consisted of 498 patients subjected to transorbital lobotomy and followed with one exception for 1 year and most of the others for periods up to 5 years or until death. Personal interviews were of major importance together with letters from patients and relatives, telephone conversations, and reports from physicians and hospitals. The data were assembled on worksheets and transferred to punch cards for greater ease in handling.

The cards were divided into 2 groups based on social adjustment at the end of the second year after prefrontal lobotomy and after the first year for transorbital lobotomy. Those with good adjustment numbered 444 and those with poor adjustment 576. Patients who adjusted well at the end of 2 years following lobotomy (1 year for transorbital lobotomy) were employed, partly employed, going to school, keeping house, and otherwise contributing something to the community. Those with poor adjustment were all those in hospital, whether or not they were engaged in some useful occupation, as well as those who remained at home in a dependent condition or cared for by paid employees. Thus it was not just the factor of living outside an institution that determined the differentiation between good and poor, but rather the contribution to the life of the community.

Of the 1,120 patients originally included in the study, 100 were dropped for various reasons before the end of 2 years. This group consisted of patients with painful and other nonpsychiatric disabilities, patients who succumbed before the end of the period of

stabilization, and those who were reoperated upon less than 2 years before evaluation. Thus the total number of cases varied somewhat at different periods of evaluation. Preliminary investigation of the figures showed that the 2-year period following prefrontal lobotomy was the most satisfactory because of the inclusion of the most patients. In later periods, while the social effectiveness was equally good or even improving, the numbers were reduced and the aging factor became of importance. Similar considerations prompted the choice of the 1-year postoperative period for the transorbital lobotomy series, an insignificant number of them being followed beyond 5 years. (Transorbital lobotomy was not begun until 1946, nearly 10 years after the start of prefrontal lobotomy.)

## STABILIZATION AFTER LOBOTOMY

The first question concerns stabilization following lobotomy. Many of the previous studies have been terminated prematurely. The 10-year follow-up by Freeman and Watts(4) of their first 20 cases and the 12-year follow-up by Furtado(5) of the original Moniz cases left something to be desired because of the newness of the surgical approach. Investigations by the Connecticut (6) and the Boston groups (2, 7) dealt with varied material, followed for 2 years by the former, and from 1 to 4 years and then for the fifth year by the latter. The numbers in the study were adequate. These studies indicated that the operated patients as a whole held their gains. Relapses after successful lobotomy, on the other hand, have also been reported(8) even many years after operation. While these cases are theoretically important, they are not too numerous to warrant pessimism in regard to lobotomy. It is estimated that 10% of patients undergoing lobotomy will need reoperation. This represents less than half of the absolute failures, those who do not improve as the result of any operation on the frontal lobes.

Golla(9) pointed out that there is progressive reintegration of the personality in the months and years that follow successful lobotomy since the infinite lability of the nervous system allows it to reach its objectives by indirect pathways when the direct ones are blocked. He says:

> Anyone who watches the process of reintegration in a relatively undamaged psychotic personality after leucotomy can trace month by month a return of the power of self-objectification, the sense of personal responsibility so completely lost immediately after operation.

The patients in this study have shown gratifying stability and even improvement in social adaptation in the various periods after lobotomy. The results are given in Fig. 1. This shows that there is a rapid (within 6 months) return of a substantial percentage of disabled patients to some form of useful activity. Furthermore, there is an increasing number of patients attaining similar levels in the subsequent years after operation. The figures for the 5-10-year period seem valid for the prefrontal lobotomy group and those for the 2-5-year period of the transorbital lobotomy group. Beyond this, the number of cases is small, and 2 contrasting factors exert directly opposite effects. In the early period of prefrontal lobotomy relatively few schizophrenic patients were operated upon, only 12 being included in the first Freeman-Watts(10) monograph. On the other hand, in the early years of transorbital lobotomy an inordinately large number of chronic schizophrenic patients was included. The first 200 cases of transorbital lobotomy were subjected to a minimal operation rather comparable to the original Moniz procedure. Making allowances for these distortions of the farther end of the curve, it can be seen that the results of lobotomy are quite stable. Furthermore, the period of stabilization appears to be at the end of the second year in the prefrontal series and at the first year following transorbital lobotomy. The distinction between the 2 types of operations will be discussed later.

## HIGH LEVELS OF ACHIEVEMENT

The next question that might be asked is how high these operated patients can rise in their social milieu. A few patients are living a fuller, more effective, and more mature existence than they did before they became sick. The operation in these patients appears to have freed them from exaggerated self-consciousness and fear of the future to the

extent that they can throw themselves wholeheartedly into community enterprises and become leaders in civic groups. A number of schizophrenic girls have grown up emotionally and socially, have married and borne children. The operation in these cases seems to have stabilized them—and their husbands and children, too—at a level they might possibly have attained without psychosis plus lobotomy, but which appeared somewhat dubious in view of the personality deficiencies they manifested during adolescence. It is difficult to compare an adolescent girl with her mature counterpart, so it is only the outstanding cases that deserve consideration. It is much the same with men. It is doubtful whether more than a handful of the lobotomized men have risen beyond their prepsychotic status, but there is that handful, nevertheless, indicating that such possibilities are not destroyed by lobotomy. One boy with a broken neck, lobotomized for unbearable pain in 1949 and still paralyzed in both arms with no voluntary movement below his shoulders, has taught himself to draw, holding his pencil strapped to his wrist. Lawyers, corporation executives, and engineers are among the lobotomized patients, and one

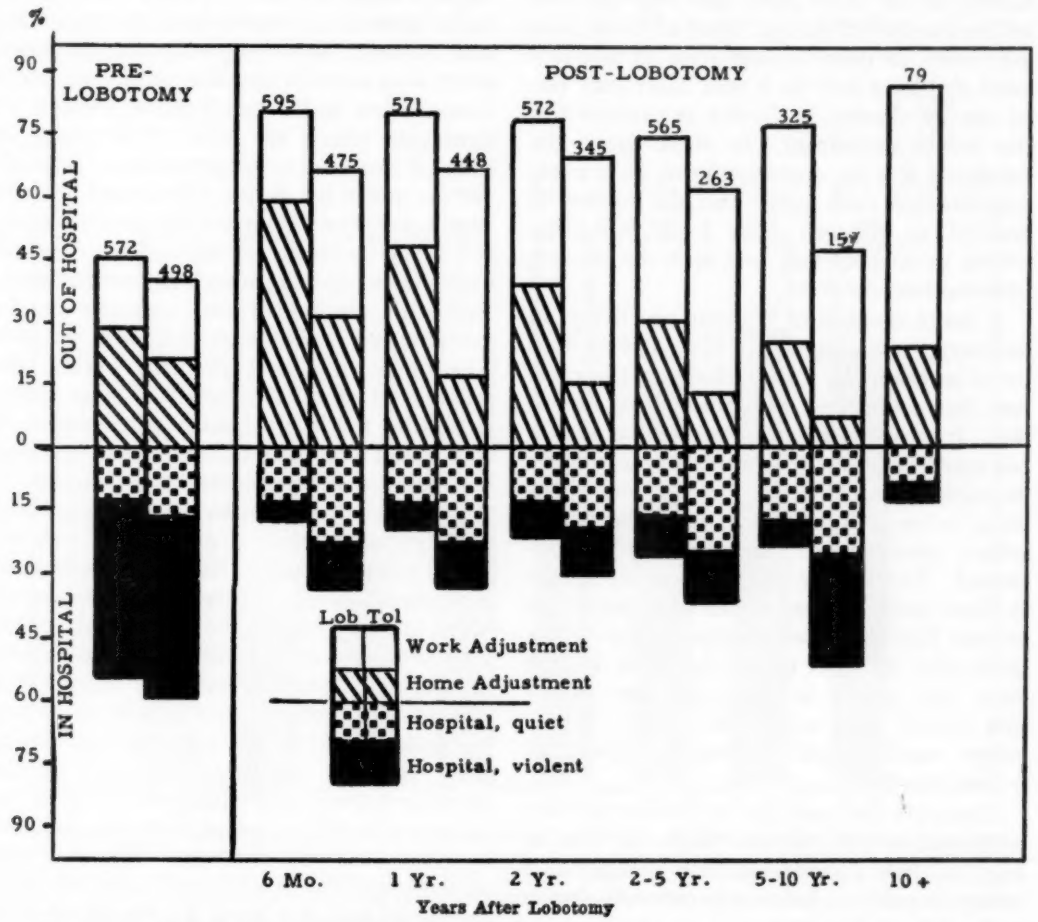



FIG. 1.—Stability of improvement in the periods of observation after lobotomy. The left half of each column indicates prefrontal lobotomy patients, the right side indicates transorbital lobotomy patients. The figures at the top of each column refer to the number of patients followed through the period (shown at the bottom of the chart). For purposes of comparison, the number of patients has been reduced to percentage figures and the distribution is shown at the left of the chart. The discrepancies at the right end of the chart are explained in the text.

physician in active practice. These are gratifying exceptions to the general rule that patients must sacrifice something in their personality in obtaining relief from intolerable distress.

A respectable number of patients are functioning at the same level that they attained before the mental illness. Most of these have gone back to their former level of achievement and have held to it year after year until age or change in family responsibilities has led to retirement. In these cases, the psychosis and the operation have, as it were, counteracted each other and the patient is enabled to proceed with little indication within or without that any such devastating interruptions occurred.

A large number of patients are living an ordinary, undistinguished life, slightly flattened emotionally, a little slow, a little careless, but continuing with their usual activities. It may be that the rest of the family has made some readjustments to the slightly damaged personalities. These patients continue to live at home and go about their tasks with a minimum of discomfort to all concerned. The beneficent effects of operation in these cases can sometimes be noted in the greater freedom from tension in the household—the full ash trays, the book on the floor, the nylons in the bathroom—things that would have made the finicky housekeeper uncomfortable before the advent of mental trouble.

These are the 3 groups of patients that are combined in the columns above the line in Fig. 1. For comparison, the preoperative rating of patients before operation is shown at the left of the chart.

### FACTORS DETERMINING THE OUTCOME

Many variables have been studied with charts too numerous for presentation in an effort to determine what were the important factors in restoring a neurotic or psychotic patient to effective living. Sex and race were unimportant. The only periods when age was of importance were from 16 to 20 when poor results were 2 to 1, and the age above 50 where good results were 2 to 1. Education was a notable factor only in the poor results of those who never passed beyond the fourth grade. Even those with professional education showed approximately equal rates for good and poor levels of achievement. As far as occupation was concerned, housewives showed a slight tendency to favorable reaction, while those patients who broke down during their years of schooling showed a slightly unfavorable tendency. Single patients showed up somewhat less well than married ones, and those who married twice better than those divorced or separated. Economic status and urban location showed no significant effects on social achievement in spite of the theoretical possibilities. Wealth did not make for better adjustment even in rural areas. Preoperative complications in social behavior such as alcoholism, financial imprudence, and vagrancy were not common. Persistent alcoholism and vagrancy in the preoperative period were followed by poor adjustment in almost all cases. When the number of hospital admissions was correlated with the level of social achievement, it was found that little difference existed until the number of hospitalizations reached 5; then the results were predominantly inferior although occasionally a good result was obtained when the patient had been hospitalized 9 or more times. Contrary to preconceived ideas, and contrary to the findings of Greenblatt and Solomon (2), the presence of a poor premorbid disposition was of no significance nor was the factor of external stress of any particular note in the later adjustment of these patients. Associated diseases of the nervous system were usually followed by inferior social adjustment, a fact also disclosed by Greenblatt and Solomon. This was particularly evident in arteriosclerosis and neurosyphilis and to a lesser degree encephalitis and epilepsy. Congenital defects, however, were not of bad omen and a fairly large percentage of patients with residuals of cerebral thrombosis attained a satisfactory level of achievement. Accompanying somatic diseases were few and of no particular significance in the outcome.

The outstanding factor in the preoperative study of the patient was the duration of disability as shown in Fig. 2. The duration of illness was a much less significant factor. This relationship has not been clearly perceived before this time probably because attention has been concentrated upon patients with chronic as well as severe mental dis-

orders. From these data it may be seen that chronicity is a severe barrier to restitution to good social achievement. The patient who is still working, but who has "reached the end of his rope" and is faced with disability or suicide, has an 80% chance of returning to a good level of achievement. This percentage falls progressively to between 20% and 25% when he has been disabled for 5 years or more. The fact that even 1 of 5 patients can still regain an effective level of existence after this long period of disability should raise hopes for many patients who are now considered beyond medical or surgical help. As it becomes clearer that lobotomy seldom actually prevents effective return to normal, the operation can safely be undertaken while the patient is still equipped to carry out his responsibility in the world of his fellows. Fixation and deterioration rather than the operation itself are to be feared. Where such signs are perceptible, it is safer to operate than to wait.

The time relationships are equally evident in the duration of hospitalization. Here the margin of safety as far as the duration of conservative treatment is somewhat narrower. Patients who have never been hospitalized and those who have been hospitalized less than 6 months stand a 2-to-1 chance of regaining effective social existence. Those operated upon during their second 6 months of hospitalization (not necessarily continuous) have an even chance, while those in whom the operation is delayed until from 1 to 2 years of hospitalization have only 1 chance in 3 of returning to a satisfactory level of achievement. They may be able to leave the hospital, but they are not equipped with those characteristics that make for adequate social adjustment. Nevertheless, patients hospitalized even for a total of 7 or more years have about a 10% chance of again resuming useful social living. Hope should not be abandoned even in the face of many years of hospitalization. Individual

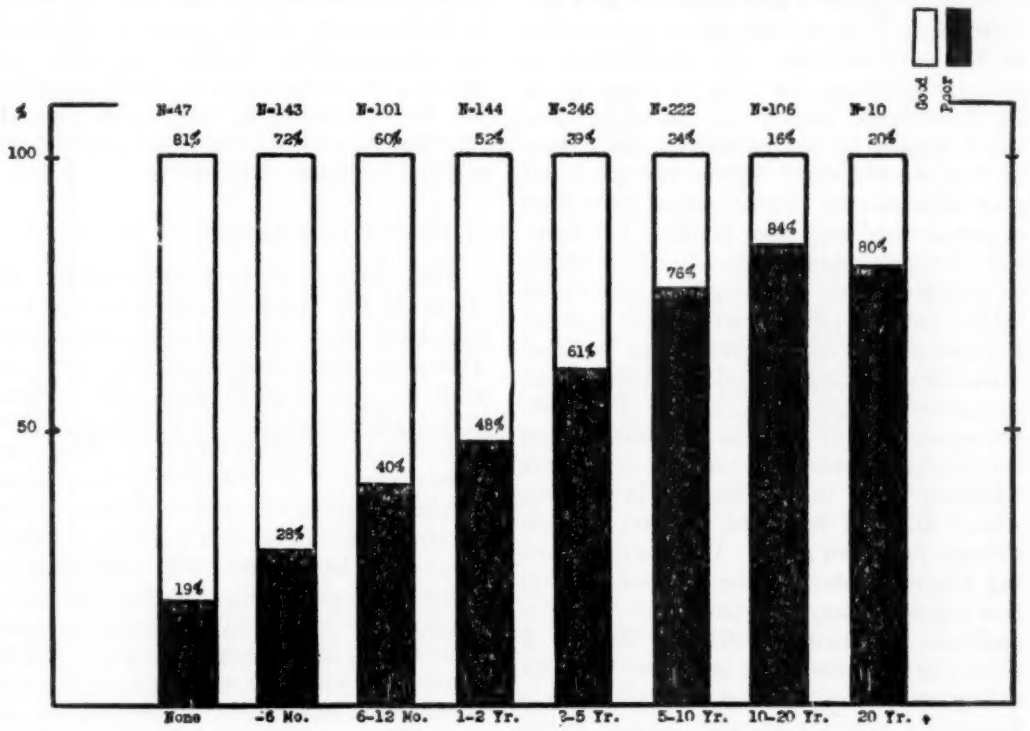



FIG. 2.—Level of achievement in relation to duration of disability. N refers to the number of patients disabled for each period shown at the bottom of the chart. The white column indicates those patients who were working, keeping house and otherwise usefully occupied after stabilization (2 years after prefrontal lobotomy, 1 year after transorbital lobotomy). The black column includes all hospitalized patients as well as those living at home, but in a dependent condition.

case reports of patients with extremely prolonged periods of hospitalization make interesting reading, but these cases are the exception.

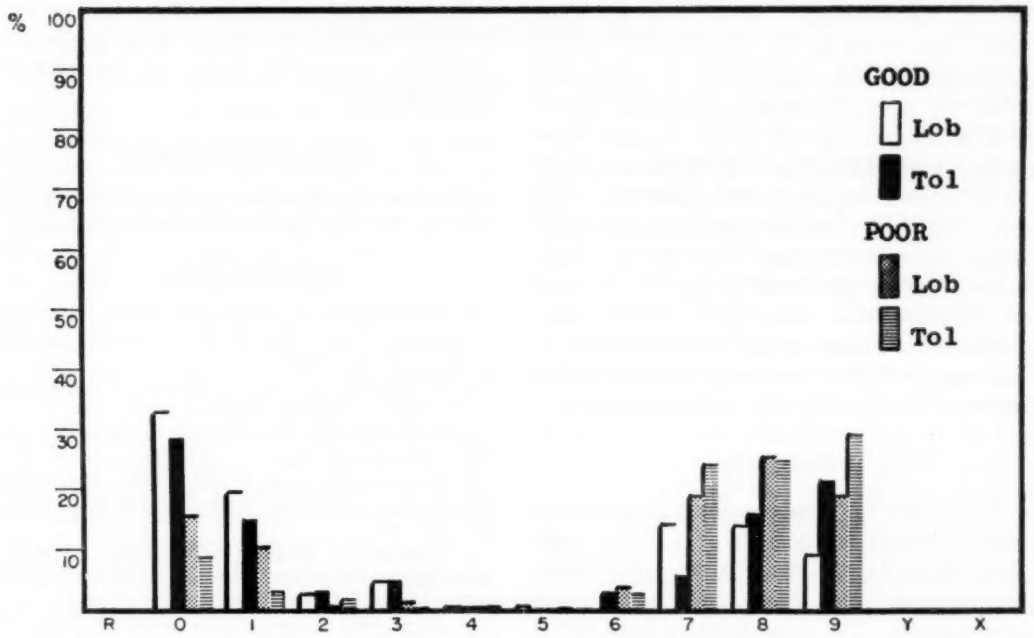
Duration of disability or of hospitalization should not be considered alone but in connection with the treatment applied during this interval. Information has been gathered dealing with both psychotherapy and shock therapy. Psychiatric interviews are here differentiated from psychoanalysis as recorded in the case histories. No qualification is stated concerning the type or intensity of psychoanalysis, merely its duration. Patients treated by psychoanalysis for 1 year or less showed equal figures for good and poor achievement. Those treated more than a year showed only poor results. The number of cases treated surgically after failure of psychoanalysis was small. A somewhat larger number of patients treated psychotherapeutically (some of these may have had a modified psychoanalysis) showed a slight preponderance on the good side. However, the psychotherapy given at the hospital level was marked by distinctly poorer results after lobotomy than those obtained in patients whose histories indicated that no psychotherapy had been given. These are confusing figures in view of the common opinion that psychotherapy, and particularly psychoanalysis, is eventually effective so that it should be continued even in the face of difficulties and discouragements. It would seem from these figures that, when psychotherapy fails, the problem of the surgeon is increased.

Somewhat the same question was asked and somewhat the same replies obtained when the topic of preoperative shock therapy was considered. Insulin shock either alone or combined with electroshock or metrazol shock was followed by a higher percentage of operative failures than other types of shock therapy. No shock at all or electric shock under 10 treatments was followed by a higher percentage of success. Nor was there any comfort to be derived from a study of the effects of shock therapy. Patients treated repeatedly by courses of electroshock or by maintenance shock did poorly while those who became worse after shock therapy benefited more from lobotomy. A short course of electroshock with transitory improvement seemed to be a somewhat favorable omen, but even improvement sustained for more than a year following a course of shock treatment was of no great prognostic value. Patients showing no benefit from shock therapy on the whole did worse than those showing transient effects. It was hoped that in the study of a large series of cases submitted to various types of shock therapy some predictive value of shock therapy would be forthcoming, but the results of this study are disappointing. Neither the type, the amount, or combination of shock therapies, nor the results can be used as an adequate criterion for determining which patients will respond favorably to lobotomy.

### DIAGNOSTIC CATEGORIES AND OPERATIONS

The various diagnostic categories are shown in Fig. 3 together with the types of operations employed in the respective groups. This chart, more than any of the others, reveals the type of patients brought to operation, a spectrum, as it were, of the application of lobotomy in mental disorders. This chart shows that 2 of 3 patients with involutional psychoses can be returned to effective living. In obsessive tension states about the same results can be obtained with prefrontal lobotomy and even better results with transorbital lobotomy, 4 of 5. Hypochondriacs show hardly any failures with prefrontal lobotomy and about 3 successes in every 5 with transorbital lobotomy. Anxiety states are almost always relieved by lobotomy; the few poor results showing up in the prefrontal column are due not to failure to relieve symptoms, but to the production of undesirable personality changes after too radical an operation. The few manic-depressive patients are about equally divided between good and poor and with both operations.

Turning to the schizophrenic end of the scale, it can be seen that lobotomy of any type is rather ineffective in the simple and unclassified types of schizophrenia. Following this are 3 interesting columns dealing with the main types of the disorder and the variable results obtained by the 2 types of operation. While lobotomy in the main is successful in restoring less than half of the schizophrenic patients to effective social achievement, the results in the paranoid




**CODE KEY**

0. Involutional Psychoses
1. Psychasthenia - Compulsive States
2. Hypochondriasis
3. Anxiety States
4. Manic Depressive - Depressive Type
5. Schizophrenia - Unclassified
6. " - Simple
7. " - Hebephrenic
8. " - Catatonic
9. " - Paranoid

FIG. 3.—Diagnostic categories in relation to good and poor results of prefrontal and transorbital lobotomy. This chart gives a "spectrum" of the types of patients operated upon—large numbers of schizophrenic patients (right) and of patients with involutional and psychoneurotic disorders (left). Each column is divided into 4 shafts; the white column indicates good results from prefrontal lobotomy, the black column indicates poor results from prefrontal lobotomy. The hatched and barred columns represent similar aspects of patients treated by transorbital lobotomy. For comparison in an individual diagnostic category, therefore, the first and third shafts of a column should be compared with the second and fourth shafts. It is thus seen that transorbital lobotomy achieves proportionately better results in all categories except that dealing with hebephrenic schizophrenia. Here the effects of prefrontal lobotomy are definitely superior.

type are the best. Here the transorbital method has a moderate superiority over the prefrontal method. The operations are about equally effective, 35% to 40% in the catatonic type while in the hebephrenic type of schizophrenia the superiority of prefrontal lobotomy over the minor operation is most clearly shown. About 40% of the hebephrenics are restored to effective social capacity following prefrontal lobotomy while less than 20% of similar patients respond to transorbital lobotomy. This group of patients, marked particularly by the presence of hallucinations, deserves closer scrutiny. Perhaps the better results of prefrontal lobotomy are due to severing the connections between the frontal and temporal lobes.

## Summary

More than 1,000 lobotomized patients have been followed for periods of 1 to 16 years, then divided into those with good social achievement and those with poor social achievement. The records were analyzed in an effort to determine the factors responsible for good adjustment. It was found that the level of achievement improved with the passage of time.

The outstanding feature in a high level of achievement is the short duration of disability. Since community activities and professional competence are possible after lobotomy, it is apparent that the personality downgrading generally attributed to lobotomy should be attributed rather to the devastating effects of the underlying disease process. It is safer to operate than to wait.

Transorbital lobotomy yields a higher rate of good social achievement than prefrontal lobotomy except in cases of hebephrenic schizophrenia.

## ACKNOWLEDGMENT

The large job of coding, sorting, calculating, and charting was done by Ann McCloskey, A.B.

## BIBLIOGRAPHY

1. Solomon, H. C., et al. Pros and cons of psychosurgery. Dig. Neurol. & Psychiat., Inst. of Living, **17**: 423, 1949.

2. Greenblatt, M., et al. Studies in Lobotomy. New York: Grune & Stratton, 1950.

3. Partridge, M. Pre-frontal Leucotomy. Oxford: Blackwell, 1950.

4. Freeman, W., and Watts, J. W. Psychosurgery during 1936-1946. Arch. Neurol. & Psychiat. **58**: 417, 1947.

5. Furtado, D. Results of leucotomy. A twelve years follow-up. Proc. I Internat. Conf. on Psychosurg., Lisbon; Atica, 1949, p. 171.

6. Friedman, S., et al. A progress study of lobotomized and control patients. Am. J. Psychiat., **108**: 10, July, 1951.

7. Greenblatt, M., et al. Five year follow-up in one hundred cases of bilateral prefrontal lobotomy. J.A.M.A., **151**: 200, Jan. 17, 1953.

8. McLardy, T., and Davies, T. L. Clinical and pathological observations on relapse after successful leucotomy. J. Neurol., Neurosurg. & Psychiat., **12**: 231, 1949.

9. Golla, E. L. Preliminary remarks by the chairman. Act. Scient. et Industr. **1170**: 7, 1952.

10. Freeman, W., and Watts, J. W. Psychosurgery, 2nd edition. Springfield; Thomas, 1950.

# THE CONTRIBUTION OF THE FATHER TO THE MENTAL HEALTH OF THE FAMILY[1]

LEO BARTEMEIER, M.D., DETROIT, MICH.

The Cornelian Corner was established 7 years ago to foster more healthy and satisfying relationships between parents and their children. However, the members of this organization have of necessity devoted their energies almost exclusively to the relationships of mothers and their children because the Cornelian Corner is primarily concerned with the earliest period of human development.

The reason for this is well known to serious students of personality and human relationships. The great discoveries of Freud and all the investigators who succeeded him have repeatedly demonstrated that the inherited instincts constitute the basic structure of all subsequent personality growth and development, and that their management or mismanagement by the mother during the period of infancy and babyhood determines very decisively whether the adult will remain healthy or succumb to serious mental disorder. Inasmuch as the entire life of the child during infancy and babyhood is completely under the sway of the instincts and the striving for their immediate satisfaction, we readily understand why the physicians of the Cornelian Corner have attached such great importance to the early mother-child relationship. They have not overlooked the influence of the father in the life of the mother and the child, but they have appreciated that his influence during the neonatal period affects the child indirectly and less patently and that they had to deal with first things first.

It is an interesting fact that the educational program of the Cornelian Corner, which began about 6 years ago, was at first directed solely to physicians and obstetrical nurses and that it was arranged for parents and prospective parents only somewhat later. The reason for this sequence has been previously documented but inasmuch as I am concerned on this occasion with the contributions of the father to the mental health of the family it will be well to speak of it again.

In addition to all of the influences from her own childhood a mother's attitude toward her child is also considerably affected by the opinions of the physicians and nurses to whom she entrusts herself during her pregnancy, during childbirth, and during the first years of her child's life. The attitudes and opinions of obstetrical nurses are enormously influenced in turn by the physicians whom they assist in the care of mothers and their infants. It is the physicians then in the last analysis who exert a powerful influence in advising mothers and prospective mothers about the care of their babies. Their knowledge and skill have greatly reduced the mortality rate of both mothers and newborn infants, but their medical education and training were often more scientific than human. Their principal aim has been to prevent infection and they have succeeded most admirably.

It was natural, therefore, that artificial feeding was, for example, from their point of view, a more exact and scientific method than the more natural nursing of infants. The professional education and training of most physicians did not include any information about the all-important factor of the instincts in the mother-child relationship, and the first educational program of the Cornelian Corner was therefore intended to fill this lack in professional training. I have felt the necessity to speak about this because I would remind you that the authority invested in physicians by mothers and prospective mothers is the same authority with which their fathers were previously endowed, and that the doctor, in the role of father, has a very considerable contribution to make to the mental health of the family.

While it is true that a woman's attitude toward pregnancy, childbirth, and motherhood has been definitely moulded and determined by her relationship with her own parents and siblings, it is equally true that her emotional needs in her relationship with

[1] Read at the 109th annual meeting of The American Psychiatric Association, Los Angeles, Calif., May 4-8, 1953.

her husband are of major importance for her sense of well-being. How adequately or inadequately his relationship with her satisfies these needs determines very importantly how well or how poorly she functions as a mother to their children. There are women whose needs cannot possibly be satisfied by their husbands because they are already too severely conflicted from their childhood. They are exceptions. The women I have in mind are the ones whose conflicts are less deeply rooted and less intense. Their emotional security is improved by a good marriage.

To give consistently to her child the love he needs, a woman needs the consistent love of her husband and the certainty of his love for their child. From a psychological point of view she and the child are one, and disinterest on the part of her husband toward their child is experienced as a lessening of his love for her. The father's influence on the mother-child relationship has been too frequently overlooked, in our evaluation of the factors contributing to the dissatisfaction that so many infants and little children experience at the hands of their mothers. It has been overlooked because it is painful indeed to look facts in the face and to admit that we as fathers might have affected our children to their detriment even in the days of their infancy. It has been overlooked because mothers tried to excuse the fathers of their children and because they even conceal from themselves certain unpleasant facts about their husbands that disturb their relationships with their children. Whatever emotional damage is inflicted on a child during the period of infancy has far greater effects upon the future character development than a similar damage inflicted at a later period when the personality has become more fully organized. This is one of the reasons why the Cornelian Corner has devoted its principal effort toward better parent-child relationships during infancy and babyhood.

A mother's feelings of dissatisfaction may spring from other sources, but we are concerned here with the father's influence on the family and we must limit ourselves accordingly. He is certainly the most important person in the mother's life and the one who has the power to affect her most deeply. Whatever untoward effects he may have upon her are in turn experienced by their child. As I have indicated, she may not be aware of any antagonistic feelings, but the infant may sense them through her tenseness, through her lack of customary gentleness, through awkward movements, which are frightening to an infant, or through the cessation of her breast milk. The infant may react to these changes in its mother in a variety of ways, but most frequently by refusing nourishment, by vomiting its feedings, by colic, or by being so consistently cross that one recognizes something is awry. Many pediatricians are coming to recognize these reactions in their infant patients as disturbances connected with the mothers but are unaware of the indirect role the father may have played in bringing them about, and if the mothers are aware of them they are the last to speak of them through fear, pride, or the painfulness of it all.

I observed the following incidents within the past few months in the life of a mother and her second child. She and the baby made a satisfactory recovery from the birth experience and after several days during which the infant took his feedings very well they returned home from the hospital. The father, who had regularly visited his wife while she was confined, unexpectedly announced that inasmuch as she and the baby were getting along so well he thought he would go fishing within a few days. He had been working very steadily, spoke of feeling tired and in need of a vacation. The following day their infant developed diarrhea, cried with pain, and refused all nourishment. The pediatrician thought it best to hospitalize him and within a few hours after this separation from his mother his symptoms vanished and he was taking his same formula with seeming satisfaction. He had been given no medicines or treatments of any kind. Two days later he was returned home, and when his symptoms reappeared the pediatrician said that his trouble must be in his handling. A nurse was provided and once more he recovered quickly. The father, who was about to leave, now decided not to go and spent several days about the home. After a week's time the mother discharged the nurse and resumed the care of their baby; and now that her anxiety had been dissipated through her husband's change of mind, their infant manifested no sign of illness. It is of interest that neither she nor her husband had any awareness of the real source of the disturbance but to one who knew them both very intimately the cause and effects were obvious. She was one of those women whose mask of independence and strength was only a thin veneer and her anxiety was easily aroused. She had raised no objection to her husband's planned departure and was honest with herself when she told him she was cer-

tain they would manage all right without him. He was a man who ordinarily had a good understanding of his wife's needs but who occasionally behaved as though neither she nor their children existed. At these times his psychological vision would shrink to the circumference of his own needs. It so happened that he almost invariably behaved this way during the most critical periods of their relationship.

In order to contribute to the mental health of the family it is essential that the father shall have been prepared by the experiences of his own childhood for the role in which he finds himself after marriage. We hope that he had a good father and that he found it possible to make a strong identification with him; that during his growing years his relationship with his father was such that he craved to be like him, to acquire his traits of character and the principles by which he lived.

This process of identification with his father is one that begins in those early days when a little lad puts on his father's hat and tries to imitate him in various childish ways. It is a natural process, which begins with consciously determined imitation that later becomes automatic and continues throughout the growing years, provided it is not interfered with too seriously by either one of the parents. It is essential for the masculine development of his personality that a boy shall have a model. We say that he gets his masculinity from his father. Boys who are raised in fatherless homes can identify themselves only with their mothers, and when they have become fathers themselves they are more likely to be motherly than fatherly to their families. If they have had substitute fathers in their childhood as, for example, uncles, a much older brother, a grandfather, or an older male cousin who consistently manifested a fatherly interest in them, they may develop the traits of character that will make it possible for them to become good fathers themselves. Such experiences are rather hazardous, however, and seldom as wholesome for the development of a boy's personality as having his own father.

To become a father who can rather consistently contribute to the mental health of his family we hope that in his childhood this man will have had a mother whom he could love and respect; a mother who accepted his affection and who gave him the feeling of wanting to care for her and to protect her; in short, a mother who helped him feel manly. We hope that to a certain extent he was able to identify himself with her; that in some respects he wanted to be like her and that he gradually acquired some of her characteristics. We hope that she was a mother who helped him to understand her and that he had the opportunity to share her joys as well as her sorrows. We hope that she gave him the feeling that she understood him and that she had faith and confidence in him and that she loved him unconditionally. We hope that she taught him how to look after and care for his younger brother or sister when it was necessary for her to be absent from the home or when her duties required his assistance. We hope that she encouraged his relationship with other boys and girls and that she saw the need of his transferring his affections to someone of his own age and becoming liberated from his attachment to her.

Whether a father contributes to the mental health of his family or whether he interferes with it is determined in large measure by the extent to which he has gained insight into, or otherwise overcome, the more severe emotional conflicts of his own childhood. These conflicts are invariably connected with his father, his mother, or his brothers and sisters. If they have not been at least partially resolved before his marriage it is likely that they will tend to reappear once he has become a father in his own right. It is well known, for example, that many men experience periodic depressive and anxiety states during the pregnancies of their wives. They experience concern about the well-being of their future offspring. They express fears that the baby may be underdeveloped, that it might be injured during birth, or that something will happen to it.

These morbid mental states are manifestations of unconscious hostilities that they experienced toward a brother or a sister at the time of their births and that they have never been able to resolve. Their childhood conflicts are reactivated by the pregnancies of their wives; psychologically their wives take on the significance of their mothers and their children become brothers and sisters with

whom they must compete and toward whom they bear a persistent resentment. Some of the depressive states these fathers develop become so severe that they may attempt suicide when their children are born. Several years ago, Zilboorg published an article entitled "Depressive States Related to Parenthood." In his study of fathers who had developed these disorders he pointed out that we do not think it uncommon for women to become depressed and anxious but fathers are equally susceptible.

It is very important that fathers have insight into, or that they liquidate, their unconscious hostilities toward their children for otherwise they tend to be over anxious about them, or too authoritative or strict with them. A father whose unconscious hostility to his son expresses itself in his being unreasonably strict with him can see only bad possibilities in the boy and is incapable of developing a sense of charitableness toward him. His unconscious hostility consists of the hatred he felt toward his brother in his childhood; because he never overcame this he is bound to treat his son as he wished to treat—or as he may have actually treated—his brother in a former time. The intensity of his orginal feeling would never have developed, or would have been diminished, had his parents prepared him for the birth of his brother and made it possible for him to participate with them in this major event.

In addition to the unconscious handicaps that the father might have, there is a handicap created by our culture and our civilization for which one is hard put to find a name. This handicap is best described as follows: Loving almost means being soft. Being gentle and kind almost means being a sissy. A loving and gentle father is consciously or unconsciously looked upon as a psychological failure in the sense that he isn't really a *he*-man. A great many family tragedies in which children fail to develop normally and grow up to be either lazy bullies or aggressive, conceited, sterile members of society have developed as a result of the fact that the father either did not dare to be soft and gentle or that his softness and gentleness were mistaken for femininity and weakness. Mistaken by whom? Here is the rub. The ideals, in a psychological sense, that a father tries to imprint on the child are frequently and effectively, although not at once visibly, combatted and destroyed by our so-called civilized attitude in schools, businesses, colleges, teams, and clubs where the ideal of ruggedness and toughness denies as a matter of psychological fact the guiding light of paternal solicitude, love, and affection. This is a handicap for which we have no solution.

# PATTERNS OF BEHAVIOR DISTURBANCE FOLLOWING CATARACT EXTRACTION[1]

LOUIS LINN, M.D., ROBERT L. KAHN, PH.D., ROBERT COLES, M.D., JANICE COHEN, B.A., DOROTHY MARSHALL, R.N., EDWIN A. WEINSTEIN, M.D.

## INTRODUCTION

Behavior disturbances following cataract extraction have been described since the early nineteenth century. Most case studies have dealt with gross psychotic phenomena. In general, they emphasized the transitory nature of the changes, noting their occurrence primarily following operation when both eyes were bandaged, and their disappearance when the bandages were removed(1, 2, 3, 4, 5, 6). However, cases have been reported in which the disturbances did not subside with removal of bandages(7) and others have described psychotic reactions that appeared in spite of the fact that the eyes were not bandaged postoperatively(8, 9). A few authors carried out experiments to evaluate the specific role of eye covering by bandaging the eyes preoperatively(1, 4, 10), or placing patients in a darkened room(11), and found that acutely disturbed behavior could be provoked by such procedures. Aging or senile encephalopathy have been frequently mentioned as etiologic factors(1, 2, 3, 4, 7, 12, 13, 14, 15), as well as the presence of premorbid personality disturbances(2, 8) and the effect of drugs(8, 11, 12).

Systematic investigation of the phenomena has apparently not been carried out. It is our purpose to determine (1) the incidence and patterns of disturbed behavior following cataract extraction, and (2) some of the factors involved in producing the disturbed behavior, specifically the importance of the exclusion of visual stimuli, the role of organic brain disease, age, and premorbid patterns of behavior.

## MATERIAL AND METHOD

Twenty-one unselected patients with bilateral senile cataracts were studied on the ophthalmologic ward service of the Mount Sinai Hospital.

[1] From the Departments of Psychiatry, Neurology, and Ophthalmology, of the Mount Sinai Hospital, New York City.

Because disturbed behavior frequently was transitory or occurred only at night, each patient was observed constantly by one or more members of the staff. Information concerning the patient's premorbid personality was obtained in interviews with the patient, members of the family, and friends, and, in a few instances, from social service departments of other institutions.

On admission, each patient had an electroencephalogram and an "amytal test"(16) to determine the presence and degree of organic brain disease. The amytal test consisted of an intravenous injection of amobarbital sodium at the rate of 50 mgs. per minute until the patient showed marked nystagmus, dysarthria, drowsiness, and made errors in counting backwards. At this time the patient was asked a standard series of questions to test orientation for place, time, person, and awareness of illness. It was found that only patients with organic brain changes showed persistent disorientation or denial of illness under amytal when such behavior was not present prior to the injection.

The patient's eyes were covered shortly after supper, around five o'clock, on the night preceding the operation. At 11:00 p.m. the patient was awakened and orientation tested. The next morning after breakfast his eyes were uncovered and he was again interviewed. The purpose of this procedure was to determine the effect of simple masking on behavior, as contrasted with the postoperative period of masking when additional factors are involved.

Cataract extraction was carried out under local anesthesia in all but one patient who received a general anesthetic. Postoperatively the patients received, as indicated, codeine or demerol for pain and barbiturates for sleeplessness. The unoperated eye was uncovered on the third postoperative day, unless earlier uncovering became necessary because of increasing restlessness. During the periods of masking, both before and after the operation, side rails were applied to the bed.

## RESULTS

Twenty of the 21 patients showed some alteration of behavior during the period of hospitalization, such as changes in mood, psychomotor disturbances, delusions, hallucinations, disorientation and confabulations. The patterns of behavior may be conveniently described in relation to the time of occurrence; on admision, preoperative masking, postoperative masking, and the postoperative period after the eyes were unmasked.

## BEHAVIOR ON ADMISSION

On admission the overt behavior of most patients was friendly and cooperative, with no indication of disturbance. During the psychiatric interview, however, patients expressed anxiety concerning the insecurities of old age, the difficulties associated with the progressive diminution in vision over a period of months and years, and fear of blindness. They spoke of such problems as the inability to work and take care of themselves, the need to depend on others for financial support, and loneliness occasioned by the death of contemporaries, particularly a husband or wife. Several complained of difficulty in memory.

Almost all expressed some anxiety concerning the forthcoming operation. However, this anxiety was manifestly severe in only 3 patients. It was expressed as a fear of blindness, of death during the operation, and a fear that both eyes would be operated on. Others denied that they were concerned. One expressed it thus, "If I die, I die. What difference will it make?" Several patients reacted to the frequent interviewing and questioning with hostility and expressions of concern about their sanity. Only one patient was grossly disturbed on admission. He was disoriented for time, place, and person, gave numerous confabulations, was irritable and uncooperative.

## BEHAVIOR ACCOMPANYING PREOPERATIVE MASKING

Twenty of the patients were masked for a minimum of 12 hours during the night preceding the operation. Of these, 10 showed no observable disturbances; ten exhibited disturbed behavior ranging from insomnia and verbal expressions of anxiety to acute panic reactions. One patient in a severe panic state, associated with weakness, dizziness, and sweating, similar to claustrophobic attacks he frequently experienced prior to admission, expressed the dread conviction he would never see again. In 3 cases the anxiety became so great that the mask had to be removed; the disturbed behavior then subsided. In 2 of these the mask was then replaced; in 1 there was recurrence of anxiety. The patient who was grossly disoriented and disturbed on admission became even more disturbed and tried to climb out of bed. Five patients expressed particular concern about the side rails that were placed on their beds during the period of masking. One patient said, "I feel imprisoned. No one cares for me." Three expressed fear of wetting or soiling the bed if the nurse or orderly did not respond in time to their calls.

## POSTOPERATIVE BEHAVIOR WITH EYES MASKED

During the 3-day period of postoperative masking, 18 of the 21 patients showed some noticeable alteration in behavior. In five cases this was mild. Thirteen showed severe behavioral disturbances, as determined by the criteria of persistence, intensity, and the presence of delusional trends. The reaction was considered persistent if it lasted more than 1 day, and intense if it was readily apparent. Eight of the 10 patients who reacted with some disturbance to preoperative masking were among the severely disturbed following the operation, while only 4 of the 10 who had no observable disturbance on preoperative masking became severely disturbed postoperatively. The patterns of behavior disturbances were varied.

(1) *Psychomotor Disturbances.*—The most common change was increased psychomotor activity, shown by 9 patients in whom there was restlessness, tearing off the mask, and attempting to climb over the side rails. One patient became violent and struck himself repeatedly about the head. Another was noisy and abusive.

(2) *Paranoid Delusions.*—Six patients manifested paranoid delusions. They said they were in a prison and demanded to be

released. Several thought they were being punished. One patient thought he had been pulled off the street into the hospital. One said her purse was stolen, another that she had been forced to inhale poisonous fumes.

(3) *Somatic Complaints.*—Four patients had somatic complaints but in only one did it concern the eyes. This patient was convinced that her eyes had been enucleated. She denounced her daughter bitterly for making her undergo surgery, although the operation had actually been carried out at the patient's insistence and against the daughter's wishes. Another thought he hadn't had a bowel movement in 3 months and wanted to know why something wasn't done about it. In 2 cases there was an extreme hypochondriacal reaction.

(4) *Elation.*—Four patients showed elation during the postoperative period, characterized by high-spiritedness, talkativeness, ravenous eating, and jocularity. One patient said she had been to a ball the night before; another accounted for an episode of disorientation by saying, "Maybe I drank too much whiskey."

(5) *Hallucinations.*—Visual hallucinations were present in 3 cases. One depressed patient said he could see a large bottle of iodine, which he insisted that the nurse give him. Two patients hallucinated that people were standing in front of them. One maintained a cheerful, muttering conversation with these "people." Two complained of being behind a closed door. One said on one occasion, "I'm covered with layer upon layer of beautiful lace"; at another time she thought she was in a "strange room filled with enameled human figures that were unfriendly." She also thought she had been moved to a "brown" room, then to a "blue" room.

Two patients experienced auditory hallucinations or misinterpretations of noises that followed a pattern which we called the "delusion of violence in the street." Thus, one said he had been kept awake all night by sounds in the street of people being robbed, shot, beaten, and run down by automobiles. He denied that he had been frightened, saying, "Why should I be? I was safe and sound in my bed in the hospital." The other patient just spoke of "terrible things" going on in the street during the night.

(6) *Disorientation.*—Eight patients showed some degree of spatial disorientation. In 6 this took the form of disorientation for place; 3 believed they were home, one that he was in another hospital, one that he was in an apartment house, and one that he was at his place of business. In 4 patients there was topographical disorientation, referring to change of position of the beds on the ward. Thus, 1 patient complained that her bed had been moved to the opposite wall, another said with considerable anxiety that her bed had been moved out into the yard. After unmasking, when she became oriented she said, "It feels good to be back in my own bed again."

Four patients exhibited some temporal disorientation. One mistook a morning for an afternoon and confabulated that lunch had been offered to her but she refused it. Two others asked for breakfast or a shave in the middle of the night. One man kept asking the time because, as he said, he "did not want to lose this point of contact." Three patients denied that they had been operated on. In 2 this was accompanied by disorientation for place and the other was incontinent of urine.

(7) *Anxiety.*—Two patients displayed primarily an increase in anxiety. One became sullen and resentful, bitterly protested the side rails, and expressed great fear of blindness. He was obsessed with the fear that if the operation failed and he became blind, his wife would no longer take care of him. The other asked repeatedly that the mask be removed so that she could see her husband.

Almost all patients exhibited more than one of the patterns of behavior disturbance, especially those with severe reactions. Frequently they were manifested simultaneously, in some cases increasing in severity on successive nights. Thus, 1 patient was restless on the first postoperative night and reported the "delusion of violence in the street." On the second night he had hallucinations that continued to be present the next afternoon. On the third night he tore off his mask, confabulated that his wife was upstairs, became aggressive, and expressed the paranoid delusion that he was being kept

prisoner in an apartment house and demanded his release.

Disturbed behavior was evident as early as 1 hour postoperatively. In all but 2 cases signs of disturbances, if they appeared at all, were evident on the first night. In these 2 cases observable behavioral change was not present until the day after the operation.

In 3 cases acutely disturbed behavior seemed to subside when the patient was addressed by the nurse. In response to her voice, the patient would seem to be startled, and, for a time at least, would become more lucid. These patients spontaneously volunteered the information that they felt as if they had been "awakened from a dream."

### BEHAVIOR AFTER UNMASKING

Six patients showed marked improvement in their behavior as soon as the mask was removed. In 1 a severe hypochondriacal reaction was replaced by an elation during which the patient insisted that her vision was greatly improved. This lasted for 2 days, following which there was some return of hypochondriacal behavior. Three patients showed improvement in 48 hours. One patient showed immediate improvement, although she continued for 2 more nights to have episodes of feeling that her bed had been moved. In another the acutely disturbed behavior persisted for 13 hours following unmasking. The patient then fell asleep and woke up 3 hours later in remission, although he later showed transitory paranoid ideation. In 1 instance the delusion that the bowels were obstructed continued for 1 day after the mask was removed, but subsided when the patient became ambulatory.

In 4 patients behavioral disturbances persisted long after unmasking. Each of these patients had some grossly evident physical complication. One developed bronchopneumonia and continued to be disoriented until his medical condition improved. A patient with advanced alcoholic cirrhosis developed severe apnea during his operation and for a time was critically ill. He showed incontinence, lethargy, and intermittent denial of his operation until he was discharged. He showed transitory periods of lucidity that increased in length as his general condition improved. One man who had been grossly disturbed on admission continued to be so throughout his hospitalization, although his disturbance was more marked during the postoperative period of masking. The fourth case showed a disturbed reaction to medication which will be described more fully later.

Two patients exhibited disturbed behavior that was most marked following removal of the mask. One expressed the "delusion of violence in the street." Eight hours after his eyes were unmasked he thought he was out in the street, that a war was in progress, planes were rushing about dropping bombs and setting fires, and trains were roaring up and down. There was a riot and people were panic stricken trying to escape. When a nurse spoke to him reassuringly his panic subsided as quickly as it began. One patient, who had shown intense anxiety postoperatively, became panicky 10 hours after removal of the mask, thinking that her tongue was shrunken, that she was poisoned, and that she was going to die. This episode lasted 2 hours. She fell asleep after intramuscular injection of sodium phenobarbital and showed no disturbance on awakening the following morning. She reported the incident of the previous night as a dream and added that she had been a poor sleeper for years, subject to frequent nightmares at home.

Four patients became depressed postoperatively when their discharge from the hospital was delayed by ophthalmologic complications. One reproached himself repeatedly for having submitted to surgery. He would strike himself on the head for having been "such a fool." He had transitory paranoid ideas about the doctors, saying that all he needed was a pair of glasses and not an unnecessary operation. One patient who was depressed on admission, and developed the delusion during the immediate postoperative period that his bowels were "clogged up" in spite of repeated successful enemas, continued to be depressed when unmasked, and several weeks after his discharge committed suicide.

### BEHAVIOR IN RELATION TO THE EEG AND AMYTAL FINDINGS

Eighteen of the 21 patients had either an abnormal EEG record or an abnormal amytal response or both. In 11 cases the EEG was

abnormal.[2] The incidence of abnormal records in the cataract patients was much higher than in a group of patients of comparable age without cataracts. The amytal test was given to 19 patients and was abnormal in 13. In 6 cases both tests were abnormal and in 3 both were negative. In 3 cases the EEG was abnormal and the amytal test negative, while in 7 cases the amytal test was abnormal and the EEG normal. In 2 cases no amytal was given but the EEG's were abnormal.

It is clear that abnormal function on 1 test did not necessarily imply abnormality on the other. Seemingly, both tests measure different aspects of brain function. However, all patients in whom *both* tests were abnormal showed particularly disturbed behavior during preoperative masking and severe reactions following the operation. Of the 3 patients in whom both tests were negative 1 showed no observable behavior disturbance at any time during his hospitalization, 1 had a mild disturbance, and the third showed a severe hypochondriacal reaction during the postoperative period of masking.

### BEHAVIOR IN RELATION TO AGE

The patients ranged in age from 45 to 85. The median age was 75, and all but 3 patients were at least 70 years old. Of the 11 who were 75 or older, 10 showed severe behavioral disturbance. On the other hand, only 3 of the 10 patients under 75 exhibited such reactions. This correlation between age and behavioral disturbance may be accounted for theoretically by the assumed brain changes with advancing years. This is substantiated, in part, by the fact that all 6 of the patients with both abnormal EEG's and amytal responses are found in the older age group. However, 4 of the 5 remaining older patients showed severe disturbance which is a greater proportion than found in the younger group.

### BEHAVIOR IN RELATION TO SEX

Of the 21 consecutive admissions to the hospital, 11 were male and 10 female. Seven of the male patients and 6 of the female showed severely disturbed behavior. Though the number is small, there appears to be no relationship between behavioral disturbance and sex.

### BEHAVIOR IN RELATION TO DRUGS

Since disorientation was produced in several patients preoperatively by intravenous administrations of amytal sodium it could be expected that similar drugs given in the postoperative period for pain and restlessness might be a factor in the production of abnormal behavior. It should be pointed out however that the intravenous dose for the amytal test was 0.3 to 0.5 gm.; whereas the postoperative dose of amytal given by mouth was never higher than 0.25 gm. Furthermore, abnormalities in behavior often subsided despite continued administration of amytal. One patient received only a single 50-mgm. dose of demerol immediately postoperatively yet exhibited psychotic behavior for 3 days, a period far outlasting any possible effects of the drug. On the other hand, the one patient who showed no disturbed behavior throughout his entire hospital stay, had repeated doses of amytal sodium and demerol for 8 consecutive days following the operation. In only 1 case was there a clear relationship between the effect of drugs and disturbed behavior. This patient shouted obscene language and had hallucinations concerning dead relatives for 6 days following the postoperative removal of the mask. When his medication, consisting of amytal, phenobarbital, and chloral hydrate was discontinued, he improved promptly and his behavior returned to normal in 36 hours. Six months previously he had had a similar episode following a prostatectomy which likewise subsided when sedative medication was discontinued.

### ROLE OF THE PREMORBID PERSONALITY

Several of the patients employed defense mechanisms in the stress situation of the hospital similar to those they had been accustomed to using in dealing with problems in the past. Thus, one patient who was affable and ingratiating on admission became hostile and suspicous after the mask was applied. In his personal history he showed this same pattern, namely, a capacity to make a superfi-

[2] EEG records were read by the staff of the EEG Laboratory; Drs. H. Strauss, M. Ostow, L. Greenstein. The EEG data will be the subject of a separate detailed report.

cially friendly impression that gave way to a hostile paranoid reaction as soon as relationships became more complicated. Two patients who were extremely restless and sleepless during the preoperative masking said the next day that they hadn't been upset. In their personal history one could find the same tendency to use denial, to minimize the severity of the hardships and frustrations to which they were exposed.

The mask was often applied early in the evening while the patient was still sitting up in the day room. One patient reacted with the agoraphobic-like panic already referred to. He asked to be led to his bed. Once safely in bed his panic subsided as long as a nurse sat by his side. Here the defense was a type of regression. His use of this defense was even more striking during the postoperative period of masking when his reaction was one of euphoria. He talked volubly and laughed readily. He consumed great quantities of food with many expressions of pleasure. He said that this was the first real vacation of his life. He compared the comforts and conveniences of his stay in the hospital with that of a guest at a fancy resort. The anxiety he displayed preoperatively was entirely gone. No longer was there a fear of blindness. On the contrary, with the regression there seemed to be a joyous surrender to the helplessness and passivity which the postoperative period of blindness forced upon him. In his personal life the patient was a passive, dependent individual, frequently given to temper tantrums whenever he felt that his wife was not taking proper care of him. When the mask was removed and the day of his discharge approached, his elation subsided and in its place anxiety and depression appeared.

One patient, given to hypochondriasis all her life, displayed an extreme intensification of her physical complaints during the postoperative period of masking. When the unoperated eye was uncovered, the hypochondriasis subsided completely. Indeed, with the restoration of vision she became elated, and insisted that her vision was much improved over her preoperative status, a manifest impossibility since she was using the unoperated eye at this time. In 2 days the elation and the "delusion" of improved vision subsided. She became hypochondriacal again, although never to the same extent as during the postoperative period of masking. It was also interesting that she never referred to her eyes in her multitude of complaints. This was also true of 3 other patients, in all of whom somatic complaints were the central feature of their postoperative behavioral disturbance.

## Discussion

According to previous reports the incidence of disturbed behavior following cataract extraction in senile patients is about 3%(2, 3, 7, 12, 14, 17) although Finlay (18) reported only 1 case in a series of 294. In the present study, however, 20 of the 21 patients, or 95%, showed some alteration in behavior during the period of hospitalization, and 13 patients, or 62%, showed severely disturbed reactions following the operation. This marked difference reflects primarily a difference in the method of observation and the criteria of disturbed behavior. By planned observation of all patients on a 24-hour basis, and with daily interviewing, it was possible to perceive disturbances in behavior that might otherwise have been missed. Many times disturbances occurred at night or for transitory periods when only nurses were present. For this reason their observations were of great importance. Often alterations in mood or the presence of unexpressed delusions or hallucinations were elicited by daily questioning.

The factor of organic brain disease may be of critical importance in explaining the high incidence of psychopathology in the group. This appears to be substantiated by the fact that the most severe disturbances were found in those patients in whom both the amytal test and the EEG were positive for organic brain disease. The 1 patient in our series who displayed no observable abnormality in behavior during hospitalization was one of a group of 3 who had a negative amytal test and a normal EEG. The fact that 18 of the 21 patients had some evidence of organic brain disease suggests that senile cataract may be 1 manifestation of a more extensive degenerative process.

Organic brain disease can influence the nature of the defense mechanisms, involving such factors as the rigidity and duration of the disturbance. For instance, one patient

stated that she went out to a dance for a good time. When the examiner indicated doubt, she said, "I say this because it is better to joke than to be sick." She promptly corrected errors by saying, "At my age I have a right to be mixed up a bit," and chuckled if she addressed the examiner by the wrong name. The organic factor in this case was not marked, as the negative amytal test and the mild EEG disturbance showed. Had the disturbance in brain function been greater, she probably would not have been able to correct the error, and the joking would become a "real" psychotic experience and would then be classed as a confabulatory delusion.

One patient, for example, had both a positive amytal reaction and a marked disturbance in the EEG. This patient reacted to the postoperative period of masking with euphoria and a multitude of gaily colored hallucinations. The psychotic period was filled with material from her school days as a young woman in Germany. In the psychosis she was able to "see," she was young and carefree again. In short, she was able to deny the disagreeable realities of her current existence.

Some of the patients with spatial disorientation spoke directly of having difficulty in remembering where and how they were situated. Their experiences are reminiscent of those described by Cameron(19) in a group of senile patients who tended to become delirious at night. The patients were asked to point out, with eyes open, the location of 5 common objects in the room. They were then blindfolded and asked every 15 minutes for 1 hour to point out the location of the objects. In 13 of the 16 patients, definite displacement occurred. In some, the distortions in recall were such that the surroundings came to resemble more and more the patients' own homes.

The role of covering the eyes and of darkness in general in eliciting psychotic behavior in patients with organic brain disease is a complex one. The perceptions of the outer world not only remind these forgetful patients of their whereabouts but arouse them to a state of greater alertness. This was seen on several occasions when disturbed patients became momentarily more rational when spoken to. Paradoxically the same intense scrutiny that made possible the discovery of an unsuspectedly high incidence of disturbed behavior may, by its arousing effect, have reduced the amount of disturbance that would otherwise have occurred. A third, and probably the most important effect is its influence on anxiety. The familiar sights and sounds of ward activity are reassuring to the patient, and conversely, darkness and silence are frightening, particularly in these patients in whom fear of blindness is so prominent.

Although preoperative bandaging aroused considerable anxiety in several of our patients, in no case did it result in psychotic phenomena like those observed postoperatively. The time element may provide at least a partial explanation for this difference. Although most of the disturbances in postoperative behavior occurred by the first night, it was often found that on succeeding days it was of progressively greater severity. In other studies(7, 10, 11, 14, 20) the most frequent time of onset was on the second day. Gat and Orban(10) found that their patient had to be in darkness for about 24 hours before psychotic symptoms became manifest. It is possible that if the preoperative masking had been continued for a longer time, more varied and more intense disturbances might have occurred.

However, other factors are of great importance in producing the disturbances of behavior. The physical and psychological stress of the operation itself, the postoperative pain, the limitation of mobility, the presence of the side rails and the uncertainty about the outcome are additional sources of anxiety, and make the postoperative period a particularly stressful one.

Two patients showed disturbances in behavior for the first time during the postoperative unmasked period. In these cases the problems associated with leaving the hospital were perhaps more disturbing than the operation itself or the bandaging of the eyes. To some extent, and to some patients, the stay in the hospital was a temporary respite from problems confronting them on the outside. Their physical needs were provided for, financial worries were not an immediate problem, and they were subject to the increased interest and sympathy of friends and relatives. In such a situation, it is understandable that the prospect of leaving the hospital may precipitate acute anxiety or de-

pression and result in various disturbances of behavior.

The role of age is also complex. Apart from the factor of organic brain disease which is likely to be more marked in the older patients, psychological problems may also become more severe with advancing age, because of economic insecurity, loneliness, increased helplessness due to physical and mental infirmities, as well as diminished capacity to deal flexibly with anxiety-provoking situations. Our cases were ward patients, drawn largely from a home for the aged, and therefore the foregoing factors may have been particularly marked in this group.

In view of the almost universal occurrence of behavior disturbances in our cataract patients we believe we are justified in stating that the premorbid personality may have determined some of the elements or qualitative aspects of their disturbances but could not account for their vulnerability as a group.

The disturbances in behavior appear to represent, in part, a symbolic manifestation of a drive to deny illness, although only 3 patients showed explicit verbal denial. The hypochondriacal reaction may be interpreted as a form of partial denial. The patient acknowledges that he is ill, but says in effect that his illness is not blindness, which is dreaded, but constipation, etc., to which he is accustomed and which he has overcome many times in the past. It has also been noted in patients with organic brain disease that the major aspect of illness may be denied while the patient complains of a minor one(21).

Some of our patients displayed paranoid reactions. Here, as in the hypochondriacal reactions, the patient acknowledges that he is ill. This time, however, he reassures himself with the thought that his difficulties do not arise from within himself, but are rather the result of the machinations of others. One patient, for example, not only complained bitterly of constipation but insisted that the orderly who gave him enemas was inept and unkind. There was some evidence of recent overt homosexuality in the history. The constipation as a symptom could be conceived in terms of Freudian theory as an invitation to homosexual attack, while the paranoid attitude towards the attendant who gave the enema seemed to represent an attempt to defend himself against this unconscious wish. In this particular case, the hypochondriasis and the paranoid reaction seemed in addition to defend him against a severe depression that he had on admission. After his unoperated eye was uncovered and he became ambulatory, his complaints of constipation and ill-treatment by the attendant disappeared. With this his depression reappeared and resulted in his death by suicide several weeks after he was discharged.

The fact that the visual system was rarely specifically referred to in the patient's productions might indicate that the behavior is a total reaction to the threat of destruction or incapacity in addition to being a denial of poor vision.

Patients have been known to injure themselves gravely or to commit suicide during psychotic reactions following cataract extraction. In view of the aging population with its increasing incidence of cataracts the matter of prophylaxis is important. For example, if a patient has a positive amytal test and an abnormal EEG and develops considerable anxiety on preoperative masking, the likelihood of a severe disturbance postoperatively is rather high. One might want to single out such patients for particularly attentive postoperative care. The removal of side rails where the nursing situation permits may be of value, as well as the presence by the bedside of solicitous friends and relatives. Whereas adequate medication for pain is desirable, restlessness would be better treated not by sedation but by uncovering the unoperated eye. This should be done at the first sign of growing restlessness even if it is only a few hours following the operation. The surgical risks of early unmasking may be less than those of a psychotic outbreak. Early sitting up in a chair and early ambulation appeared to have a beneficial effect on the behavioral status of these patients. There are numerous references in the literature(22, 23) to the beneficial effect of early return home, especially in cases where the disturbance began in the hospital and did not subside after unmasking(9).

## Summary and Conclusions

1. Twenty-one consecutive ward patients admitted to the ophthalmologic service for

senile cataract extraction were studied by a team of observers. Each patient was given an EEG and an amytal test for organic brain disease. Prior to operation each patient was masked for a period of at least 12 hours.

2. One patient was manifestly psychotic on admission. The others showed varying degrees of anxiety that could be related largely to insecurities attendant on old age and loss of vision. The preoperative masking produced changed behavior in 10 patients, ranging from insomnia and verbal expressions of anxiety to acute panic reactions. Removal of the mask relieved the anxiety.

3. Following the operation 20 patients showed some alteration in behavior including changes in mood, psychomotor disturbances, paranoid and somatic delusions, hallucinations, disorientation and confabulations. In 13 cases the disturbance was characterized as severe. Unmasking resulted in prompt improvement in 6 cases, gradual improvement in 48 hours in 3. Only 4 patients continued to show disturbances after the mask was removed; in each some physical complication was present. In 2 patients abnormal behavior appeared for the first time after unmasking.

4. Some degree of organic brain disease, as shown by the EEG and amytal test, was present in 18 patients. There appeared to be a relationship between the presence and degree of brain damage and the development of disturbed behavior. The findings suggested that senile cataract may be one manifestation of a more extensive degenerative process. Older patients are more apt to show disturbances. The premorbid personality pattern seemed to be unrelated to the incidence of altered behavior, but to some extent determined the particular type of pattern exhibited.

5. It is concluded that disturbed behavior is an integral part of the reaction of almost all cataract patients because of a complex interaction of a number of factors. The implication of these findings for prophylaxis and management is discussed.

## BIBLIOGRAPHY

1. Sedan, J. A propos du delire post-operatoire en ophtalmologic. Rev. d'oto-neuro-opht., **17**: 168, 1939.

2. Preu, P. W., and Guida, F. P. Psychosis complicating recovery from extraction of cataract. Arch. Neurol. & Psychiat., **38**: 818, 1937.

3. Greenwood, A. Mental disturbances following operation for cataract. J.A.M.A., **91**: 1713, 1928.

4. Schmidt-Rimpler, H. Delirien nach Verschluss der Augen und in dunkeln Zimmern. Arch. f. Psychiat., **9**: 233, 1878.

5. Sichel, J. Sur une espece particuliere de delire senile qui survient apres l'extraction de le cataracte. Ann. d'Ocul. Par., **49**: 154, 1863.

6. Pfingst, A. C. Acute delirium following cataract extract operation. Case report. Kentucky M. J., **21**: 99, 1923.

7. Posey, W. C. Mental disturbances after operations upon the eye. Ophth. Rev., **19**: 235, 1900.

8. Butler, T. H. Insanity after eye operations. Tr. Ophth. Soc. U. Kingdom, **40**: 363, 1920.

9. Kipp, C. J. Mental derangement which is occasionally developed in patients in eye-hospitals. Arch. Ophth., **32**: 375, 1903.

10. Gat, L., and Orban, L. Nach Staroperation Auftretende Delirien. Ophthalmologica, **112**: 335, 1946.

11. Boyd, D. A., and Norris, M. A. Delirium associated with cataract extraction. J. Indiana M. A., **34**: 130, 1941.

12. Parker, W. R. Postcataract extraction delirium: Report of eleven cases. J.A.M.A., **61**: 1174, 1913.

13. Weeks, J. E. Mental disturbance following operation for cataract. J.A.M.A., **91**: 1713, 1928.

14. Brownell, M. E. Cataract delirium: A complete report of the cases of cataract delirium occurring in the ophthalmologic clinic of the University of Michigan between the years 1904 and 1917. J. Michigan Med. Soc., **16**: 282, 1917.

15. Harbridge, D. F. Senile cataract extraction followed by certain complications. Ann. Ophth., **23**: 58, 1914.

16. Weinstein, E. A., et al. The diagnostic use of amobarbital sodium in organic brain disease. Am. J. Psychiat., in press.

17. David, M. V. Le delire post-operative chez les operes de cataracte. Ann. d'Ocul. Par., **143**: 79, 1910.

18. Finlay, C. E. Delirium after eye operations. Arch. Ophth., **33**: 5, 1904.

19. Cameron, D. E. Studies in senile nocturnal delirium. Psychiat. Quart., **15**: 47, 1941.

20. Thomas, F. C. Delirium following cataract extraction. Kentucky M. J., **24**: 134, 1926.

21. Weinstein, E. A., and Kahn, R. L. Syndrome of anosognosia. Arch. Neurol. & Psychiat., **64**: 772, 1950.

22. Bruns, H. D. On the ambivalent after-treatment of cataract extraction with a note on postoperative delirium and on striped keratitis. Ann. Ophth., **25**: 718, 1916.

23. Bailey, F. W. Cataract operations performed upon patients in their own beds. J. Iowa M. Soc., **18**: 8, 1923.

# THE EFFECT OF INFANTILE DISEASE ON EGO PATTERNS[1]

ROY R. GRINKER, M.D.[2]

Probably no greater quantitative or qualitative effect is imposed upon the ego or its rudiment than that from disturbances during the earliest weeks and months of life when soma and psyche constitute one undifferentiated system. It is generally accepted that the most embryonic, most rapidly growing, or youngest somatic tissues, or maturing patterns of function are most sensitive to stress. Differentiated tissue or specialized functions are more resistant to permanent alterations imposed by stress and less able to regenerate. Our attention today is more and more directed toward the impact on psychological functions by processes occuring during the formative and differentiating periods. I have indicated elsewhere that much research is needed on the myriad influences imposed on the neonatal body—its surfaces, orifices, and internal vegetative functions—to clarify the subsequent types of psychological functioning(1). For this presentation I have chosen to discuss a serious somatic disturbance appearing at birth and lasting for 8 years. Because of its obviously severe effects this should emphasize what may happen to ego functions from lesser disturbances.

To view ego patterns from several points of view requires different operational methods. The unfolding of constitutionally derived action patterns is ascertained by detailed observations of maturing infantile functions. Unfortunately these have been mainly focused on motoric patterns and bodily structures. What requires study is a host of internal biochemical and physiological processes that are specified as to type and quantity at birth and that crucially affect first interactions. Interactions may be surmised by direct observations, or from reconstructions of child-mother symbiosis in a therapeutic setting. Transactional processes may be scrutinized by psychoanalytic techniques, by observation of total behavior in multiple life situations, or during the process of psychotherapy in a two-way interpersonal system.

When we speak of the clinical aspects of ego functions we have reference to the total behavior of the person for which the ego is the executive. But total behavior is an action process in relation to other human beings —in response to their stimulation, or as a stimulus to them, currently, before, or after communication with them, or with older memories of long-past communication. To understand these processes thoroughly would require detailed descriptions of a variety of communicatory and symbolic actions such as speech, writing, gestures, and other movements. We may, however, place these many forms of action into categories of social roles, the designations of which refer to significant functions in social transactions(2). From performances within a variety of such roles, I shall attempt to indicate the influences of somatic processes on a single subject.

*The Somatic Disease and its Course.*—F. R. was the first male child of a professional family. The father looked at his infant son as an object to which he should give every opportunity for development and achievement superior to his own. The mother was a compulsive character who ambitiously returned to school after her marriage for higher academic degrees. To their great shock, shortly after birth, the patient developed signs of celiac syndrome so serious that several times he was not expected to live. In this syndrome of unknown etiology there is an impaired assimilation of carbohydrates and fats resulting in serious debilitation and frequent intercurrent infections(3). When he ingested even small quantities of special foods, his abdomen would become distended with gas, and colicy pains and severe explosive diarrhea of foul-smelling stools resulted. He became starved, weak, and unable to resist frequent upper respiratory infections. His musculature was undeveloped, and his gas-filled protuberant belly made standing and locomotion difficult. He was irritable, cried frequently, and was generally difficult to manage. Gradually the symptoms abated and the patient gained weight and grew rapidly, but frequently exacerbations of diarrhea occurred until the eighth year.

[1] Read in the section on ego psychology at the 109th annual meeting of The American Psychiatric Association, May 4-8, 1953, Los Angeles, Calif.

[2] Director of the Institute for Psychosomatic and Psychiatric Research and Training, Michael Reese Hospital, Chicago, Illinois.

*The Early Family Transactions.*—The mother spent her entire time with the child caring for him and maintaining strict and scheduled control over his diet. She tried to withhold disturbing foods and pushed those that were good for him. He developed an invalid's mechanism for control over her actions and demanded punctuality, literal and exact fulfillment of promises and time schedules. The father concerned himself with the physical symptoms, especially the number and type of stools. Both parents attempted to prevent exposure to cold and contagion and to conserve his limited energy by restricting the child's activities. They early discerned his superior innate intelligence and gave much attention to his education. His precocity enabled them to stimulate his mental activities far beyond that expected for his chronological age. When the boy was 4, a sister was born who developed normally in all respects and whom he outwardly welcomed. After recovery from the digestive disturbances the patient made painstaking efforts to grow rapidly and develop a manly physique by exercising and partaking in physical activities to extremes. He pursued his studies in school and at home maintaining top level performance, but always by compulsive studying with great anxiety.

*The Early Behavior Pattern.*—This was characterized by social isolation from most children except for a few select intelligent boys. The patient spent most of his time in study. At times he would be attracted to a girl with whom he could not talk but felt impelled to follow or stalk, watching what she did or where she was going. Another compulsion was the collection of books he was as yet unable to understand. Among strangers he passed himself off as a foreign student. When his desires were frustrated at home he would fly into uncontrollable rage against either parent. All these behavior patterns plus his incessant drive for study and his useless anxiety over his grades, which were always excellent, led finally to his entering psychotherapy preparatory for psychoanalysis. It soon became clear that the most significant instrumental role in his life was that of a student. The patterning of this role was cyclic when observed over adequate periods of time, although during therapy the cycles decreased in duration and moved more speedily. It was possible to establish a reasonably satisfactory analogy between the study cycle and the early disturbance in food assimilation.

*Direct Digestive-Ego Pattern Analogies.*—(a) *Hunger.*—During periods of depressed inactivity, the patient became increasingly aware of a need to study and learn. He was afflicted by mounting anxiety and restlessness, with interest in work and intensified self-incrimination for his inability to study.

(b) *Greedy eating.*—After a period of work inhibition, the patient would suddenly begin to devour work assignments. The activity always started with a reasonable and logical amount of scheduling which was soon overthrown by a need for speed. This required intensive work late into the night, early mornings, and weekends. He would then not only complete the necessary work but continue far in advance, often tackling problems and assignments anticipated for another school term.

(c) *Slow assimilation.*—In this phase the patient seemed to have great difficulty, with attendant suffering, in understanding his mathematical problems thoroughly. Details stumped him and he would not pass these over to encompass the assignment as a whole. He concentrated on the minutia until he had thoroughly assimilated and mastered them. Days would pass with no progress, creating great anxiety, until, with sudden relief, he would understand and move on to the next problem.

(d) *Expulsion.*—As though distended with knowledge and satisfaction, in this phase he depreciated his colleagues' lack of thoroughness and would recount in great detail what he had learned, even if the listener should know the material. In therapy he would explain *ad infinitum* the mastered details of an interpretation that the therapist had given him.

(e) *Emptiness.*—The final phase was represented by a period of emptiness and self-recrimination. At such times he felt he must quit school, that he was a failure; and his depression would deepen.

*Social Roles in Transaction.*—(a) *Instrumental.*—The patient outwardly seems poised and friendly, greeting most people with a smile and with curiosity concerning their activities which he carefully notes. He seeks all the information he can on any subject but gives little about himself. He drives his car into strange places, learning new towns, sections of his own city, and even street sequences. Otherwise he isolates himself in his own room or in the school library. He has no male friends; never works in collaboration or studies with other students, although he is curious about their activities past and present. Although Jewish, he knows a great deal about Catholicism, and finds refuge in church dogma as a retreat from suffering or as a rationalization of anxiety. The church is both the loving, comforting mother and the punitive mother condemning him to purgatory for his sins.

Thus, the patient in his relationships in all situations seems to be oriented toward learning, in other words, to receiving and being fed. His curiosity is boundless—both active and passive—and he is wracked with horrible jealousies toward persons who know more than he in any field, no matter how much older or experienced they may be.

(b) *Expressive.*—The patient is constantly on the lookout for opportunities to be taken care of, admired, and loved. Yet he does not trust those who have to be forced. The birth of a baby to a fellow student's wife caused him weeks of anxious depression. When his own request for a few days vacation from therapy in order to make a trip was granted, the patient felt that the therapist was rejecting him. His mother is to him only a cook-housekeeper and he threatens her in rage attacks if she displeases him.

The patient is attracted to much older women, or to younger women who are married or, if they are divorced, those who have a child. He does not push himself forward but if they have the slightest contact with other men, even casual conversations, he

becomes inordinately jealous and depressed. His sexual urges are devastatingly frightening and when strong cause his nightly masturbation to increase three-fold, associated with fantasies of self-castration. Sexual impulses create great guilt feelings rationalized as church-forbidden, but masturbation is guiltless and relieving. During therapy he had sexual relations with 2 much older women. One, a foreign nurse with considerable insight, babied him and promised to support him if he married her. After she left the country he pictured her as "my wife" and longed for her, as a child does for a mother, whenever his anxiety or depression became worse.

The sexual cycle in this patient repeats the feeding cycle as a patterned response. After a period of quiesence there is intense sexual stimulation associated with longings and impulses to attack women. Overt action is just barely inhibited, but fantasies and dreams express the need for possessing women completely and frequently. Following this there is a great deal of anxious suffering, then severe guilt, and fantasties of eternal punishment. This is superseded by a quiescent period again.

During the period of guilt with fantasies of self-castration the shadow of castration wishes toward the father appear with strong envy of other men accompanied by rage attacks, often overt, toward the mother. These are followed by intense suffering, expressed as "hurting all over." During these periods the patient writhes in pain, wants to give up school, and is psychologically blocked. These reactions he attributes to guilt feelings. Yet there always is included in his self-recriminations part or all of the form and content of his angry outbursts against his mother. When the patient acted out his hostile curiosity in voyeurism his eyes itched and burned and severe conjunctivitis developed. When the material dealt with his angry wishes to attack his mother's pregnant abdomen he fantasied "harakiri" with knife-like pains in his abdomen.

(c) *The Roles in Therapy.*—The onset of therapy followed overt acts of hostility toward the father. Physical violence was also threatened toward the therapist, whose firm and restraining role was quickly and gratefully accepted by the patient who learned during an initial hospitalization the necessary control of his explosive violence. He constantly sought to escape from an understanding of his work, play, and sexual problems at first by intellectual rationalization and later by fantasies of a good mother figure or preoccupations with the good mother-church. For a long period he induced bloating, cramps, and diarrhea by ingesting peculiar food combinations or by overeating. Then he could be his old "celiac" self and escape psychological insight. Psychological interpretations were ignored, only to return in the form of sudden flashes of "spontaneous" insight that hit him like sudden blows. Depression and anxiety abated and their duration shortened. The essential characteristics of this two-way social system were the steadiness of the therapist's role, the twisting and turning physical postures, and the rapidly shifting roles of the patient searching for sympathetic sustenance, vigorous punishment, maudlin longing for an idealized mother or forgiveness from the church.

*Brief Psychodynamic Formulation.*—Because of his early somatic experiences the patient's capacity to express aggressive urges was severely limited. Love and hate were expressable only toward his own self—each separately severely threatened him if any tendency was stirred toward external expression. Hostility was the dominant affect, usually associated with hurting fantasies and inner suffering. He hated the object he needed and the subject who needed. For the most part the aggressive reactions to early frustrations remained as charges invested on the memory of the symbiotic or partially separated mother of his early months in the form of hurting inside. The ego developed largely as a pain-wracked body-ego precariously swaying between the onslaughts of ever-pressing aggressions causing anxiety and the inner suffering associated with depression. Whether expressed in search for oral or genital satisfaction, the biting, soiling, slashing fantasies interferred with all direct or substitutive satisfactions of play, work, or learning by stirring intense anxiety, experienced consciously by the defenseless ego, and by activating depression. Because of the latter, satisfactions were limited; arid, hopeless emptiness resulted leading to intensification of needy hunger. The spiral of emptiness and explosive hostility increased to the point of suicide preparations and overt hostility to his parents and ended in hospitalization and the beginning of therapy.

Psychiatrists who have become accustomed to making psychodynamic rather than nosological diagnoses after a few interviews and from superficial histories are fully aware of the difficulties of their task. The data are unrevealing of current transference attitudes, which do not have time to unfold, nor are they permitted in nonanalytic settings. Although the contents of verbalization may be interesting and even specific for the patients' problems, they can rarely be ordered into significant categories without biased selection or arbitrary emphasis. Instead, most experienced psychiatrists seek to elicit examples of the total behavior of the patient in various situations or in relation to well-defined figures who play institutionalized social roles. Thus we search for anecdotes and reactions in various social situations, as for example, at work, in play, during examinations, or at times of stress capable of producing shame or guilt, and of transactions with persons representing mother, father, and sibling figures. From these data we either intuitively or logically form an opinion as to *patterns of behavior* from which we

may hypothesize what prior somatic or psychological experiences were significant genetic factors, thereby creating a longitudinal dynamic life-model of the individual, subject to correction during further investigation or therapy.

The anecdotes from which patterns of behavior are extrapolated are performances of the total personality in relation to other personalities, and as such are evidence of type and degree of capacities that the ego has developed for communication in various social roles. The role aspirations and the type and efficiency of those assumed serve as some indices of the ego's patterning. Much has been written about social roles but these descriptions have not been well systemized into categories meaningful to the internal, preconscious or unconscious, processes within the subject.

Social scientists are as yet most interested in the overt or explicit roles assumed by the subject. The psychiatrist interested more in ego patterning is equally, or even more, interested in the covert and implicit roles in themselves or in various combinations with the overt roles. This greatly complicates and extends the necessary field of observation and requires a different method and other scales of measurement. For eliciting unconscious patterns, observation of a single or several interactions with other persons is not sufficient. What is necesary is the knowledge of social roles as played by the subject with a number of persons, in a series of situations and in varying sequence of time, while shifts in the internal state are permitted to reach threshold value. Furthermore, not only are we interested in the subject's reciprocation by adopting in various degrees the role set for him, but we also are greatly interested in the roles the subject unconsciously demands from others. What roles does he demand, how firmly and with what urgency does he demand them, and what maneuvers does he use to overcome resistance of his environment to accede to his wishes? Indeed, in a therapeutic setting, when the therapist maintains a steady role and refuses to accede to his patient's demands, the number, frequency, and rapidity of shift in roles by the patient may be used as a quantitative index of his anxiety.

For our purposes social roles represent the ego's patterned processes of attaining satisfaction, defending against disintegration, and integrating the self with others in a social system. The task of the personality to integrate conflicting inner trends, as it interacts as a whole with other humans in a variety of social systems, is great. It is no wonder that ego patterns shift in response to several facets and appear as punishment, self-rejection, or destruction. To effect the variety of demands made on the ego by many inner factors demanding their turn, requires a cyclic shift in external or total behavior and the assumption of different roles. It is for this reason that the patterning of social roles in time and often with forcefulness gives an indication of the multiple inner aspects of the person.

Clinical observations of ego functions reveal in most adults many distortions and absent or substitutive functions. Lately we have begun to direct our attention to when and how such deformations of the ego begin. Psychoanalysts and social scientists agree that much of the content of the ego and its superego and the form of the possible social roles are learned through identification with crucial humans of the early family. I doubt, however, that the significantly severe influences—those strong enough to cause severe crippling of the personality or serious psychosomatic diseases—are effectual at the age when learning of content or form of behavior is possible from the mother or others through words and gestures. In fact, I believe the available objects capable of giving rise to healthy identifications are prevented from being utilized because of earlier more disastrous experiences on the nucleus of the ego and superego that interfere with later object relations. The pattern of ego functioning develops during the primordial phase during which internal or external influences affect the substratum out of which ego functions mature; the vicissitudes of the primal psychosomatic organization influence the subsequently differentiated ego.

The experiences impinging on the early psychosomatic organization are dependent on a host of situational, physical, and human variables. Slight though these may be, they have their lasting effects, not simply through

influences on the body surfaces or the bodily orifices, but throughout the organism. We know little about the lesser effects of countless random variations of temperature, quantities and type of food substance, medications, etc., on the vegetative net or the cortical homunculus of the body image. These pattern the organization, part of which becomes ego by virtue of subsequent maturation. Learning from experience imposed on such a template cannot be ascribed only to the object that furnishes content, but also to transactions between it and already organized patterns of the subject.

Earliest influences occur when child and mother are still in the neonatal symbiotic stage. Although 2 separate bodies they are not yet somatic or psychological entities in transaction. Mother is the source of first neonatal homeostatic regulation of all functions except respiration and circulation. Depending on the infant's quantitative needs and the mother's cacacity to supply them, this symbiosis develops into a pattern of organization. Disturbances of homeostasis of the neonate and degree and speed of maternal restoration of equilibrium are dependent on constitutional factors within the infant and on the mother's personality, capacities, and the social regime in which she operates. Within any range of disequilibrium the infant's global somatic aggressive motions and crying are in the service of self-preservation and constitute charges of energy that are linked to the maternal body image laid down in the memory experience of the organism, which cannot discriminate self from not-self (4). That aspect of the child that develops into ego, after discrimination of self, becomes charged with the degree of aggressiveness toward the mother stirred up by the primal homeostatic needs and develops into the nucleus of the subsequent ambivalent personality. This nucleus influences the infant's learning capacities and subsequent ego and superego formation, and to a large degree it determines the content and form of the social roles capable of being learned by subsequent transactions with significant persons. Primary constitutionally derived action systems and early energy interactions within the symbiotic child-mother organization are most crucial in laying the groundwork for the integrations of health or the distortions of disease.

In viewing a patient such as the one I have discussed, the error of analysis limited to psychological content or emphasis on a single sequence of roles may be evident. We could focus on the sexual fantasies and activities and see clearly the typical poorly resolved oedipal relationship, consisting of feelings of sexual inferiority, castration wishes to the father, guilt-depression, self-castration fantasies, and regression, with the side-chain of hostility to the tempting and unfaithful mother. However, if we look at the ego patterns of which sexual behavior is only one example, and if we view the many roles the patient assumes in characteristic cycles with several human types, our perspective broadens and we are less likely to err. This patient clearly reveals a patterning of ego function that is consistent regardless of content or transaction providing a large enough time sequence is permitted for the cycles to develop. As these unfold, the overt roles ascribed by the transactional situation, or by the transacting persons in their demands for participation or reciprocity, are overthrown by the ego's highly patterned processes of forcing persons and situations into roles that it requires for itself.

A few remarks are in order regarding the pattern of distress that is inside—a hurting experienced both somatically and psychologically. This develops during and after excessive physiological biting and chewing of food by the hungry patient or after fantasied or overt behavioral attack on the mother. We have been accustomed to attribute this phenomenon to guilt feelings, depression, or self-punishment derived from a superego process. When we see this pattern in early life or when in adults it is referred to early oral processes, we hedge by attributing it to a precursor of the later superego which develops when transactions among the family group, usually at the oedipal period, result in internalized meaningful prohibitions. Perhaps there is such an assemblage of prohibitions, derived from negative external sanctions, in this primary inner suffering. But my material indicates that at its earliest emergence, it represents not a special psychological force nor a sense of guilt, but an integral

continuation of aggressive demanding from the mother, when self and mother are so symbiotically inseparable that self cannot feel apart nor experience guilt. This probably is a universal phenomenon, but when somatic hunger becomes so great and the mother, for whatever reason, is unable to satisfy it in time or in necessary quantity, the greed and hostility make the patient both subject and object. He says, "I am eaten up by jealousy," or, "I am being beaten up." Both represent self against self, because self and not-self were never adequately separated in the early years when hunger and gratification were so widely disparate.

What we may postulate theoretically from this and similar patients should be confirmed by careful direct studies on the developing child. We have become accustomed to using terms applicable to psychological processes in the human after ego functions have already differentiated, such as guilt, superego, masochism, sadism. Their use is faulty when applied to the child in the close child-mother relationship and are probably not correct when applied to their permanent affect on ego patterns. Perhaps the later interpersonal transactions, which remain as memory traces of relationships, crystallize around these primary nodes. But as nodes they represent not instincts nor their derivative affects, but manifestations of somatic patterns within a body ego which is child-body indistinguishable from mother-body. Therefore pleasure and pain, sadism and masochism, aggression and guilt are inaccurate polarities substituting for the inseparable combination of child-mother, which is the nucleus of a variety of personality facets.

My patient's problems are only accentuations in degree of the varying somatic processes that usually influence that differentiating personality. Permanent residues can be found in the internal organ functions and in the total behavior. When milder and less disastrous disturbances mold ego functions, subsequent learning may envelope the alimentary, depressed, narcissistic, or ambivalent core of the personality satisfactorily. The covering of this core by an assemblage of subsequent experiences may hide it almost completely(5). However, the primary core remains available to the resumption of function under certain circumstances, *e.g.*, regression. In adult life susceptibility to disappointment or frustration may be the sole observable remnant. Should this be severe enough, the return to the alimentary nucleus of the ego will be accompanied by a revival of the empty, arid, depressed outlook on life. Thus growth and development away from the primary ego patterns are possible, but also return to it through the accidents of life situations and personal transactions.

It seems clear from this and other examples why it is essential to study ego functions as they are contemporarily influenced by transactional operations in response to other humans in special situations, or as an expression of internal functions. Both these categories, the external by processes of communication of information and the internal by shifting cathexes of free energy from the somatic reservoirs, act upon that aspect of the ego that is tightly organized into a patterned way of dealing with both categories. It is the genesis of these early ego patterns, not psychogenesis, that is an important new area of basic research for the psychological and social sciences. Such an approach can add significant information to the theory and application of psychodynamics. It can be best furthered by multi-disciplinary observations on the unfolding, interacting and transacting infant.

## BIBLIOGRAPHY

1. Grinker, Roy R. Psychosomatic Research. W. W. Norton & Co., New York, 1953.

2. Parsons, T., and Shils, E. A. Toward a General Theory of Action. Harvard University Press, Cambridge, 1951.

3. Holt, L. E., and McIntosh, R. Holt's Diseases of Infancy and Childhood. D. Appleton-Century Co., New York, 1939.

4. Benedek, T. Toward the Biology of the Depressive Constellation. (To be published.)

5. Grinker, Roy R. A comparison of psychological "repression" and neurological "inhibition." J. Nerv. and Ment. Dis., **89**: 765, 1939.

# GERIATRIC WARD PSYCHIATRY

## TECHNIQUES IN THE PSYCHOLOGICAL MANAGEMENT OF ELDERLY PSYCHOTICS [1]

RAPHAEL GINZBERG, M. D.,[2] TOMAH, WIS.

The majority of elderly institutionalized psychotics exhibit the first symptoms of mental disease before the fortieth year. These patients carry the diagnoses of schizophrenic reactions of various types, of manic-depressive psychoses, and of a small number of other diseases that occur in the younger age groups. With the passage of time members of these groups add to their original mental condition a variety of diseases that are frequent in advanced life; among these arteriosclerosis is outstanding.

In about one-third of the institutionalized elderly mental patients the psychosis started in the older years. These are geriatric psychoses in the real sense; in other words, these are psychoses that occur only or primarily in advanced life. Here again it is cerebrovascular pathology that is predominantly responsible for the occurrence of this type of psychoses in senescence.

The elderly patients of both groups of psychoses—those that started at a younger age and those that began in later years—show symptoms of so-called deterioration, characterized by disturbance or impairment of memory, orientation, judgment, and the complicated mechanism of perception. Some of these individuals preserve, to a certain extent, the ability to reason; to this group belong many with paranoid delusions. In the overwhelming majority of institutionalized elderly psychotics, however, the process of logical thinking appears to be severely disturbed. Moreover, the elderly psychotic is frequently incapable of understanding the content of simple sentences and the meaning of spoken or written words, so that understanding through verbalization appears to be impossible or at least difficult. But whether the psychiatrist has to deal with elderly patients in whom the intellectual capacities are almost intact or those in whom they are considerably disrupted, the use of logic or rational methods to establish contact is usually so disappointing that many psychiatrists and the bulk of nonpsychiatric personnel consider the difficulties created as almost insurmountable.

But is establishing contact with disoriented, disorganized elderly psychotics really as hopeless as it may appear at first? Why is it possible to establish contact with some and impossible with others? Is it because of a difference in the localization of a cerebral process, or does it depend on the degree of destruction of the nervous substance? How much of it is organic and how much psychogenic? Is it the result of reversible or of irreversible processes? We can ask many more questions with but little hope, at present, of obtaining satisfactory answers. However, some observations help the psychiatrist to gain, to a certain extent, insight into the elderly psychotic's behavior.

If the processes of thinking, understanding, and verbalization are highly disturbed, the functioning on an emotional level continues to be much more preserved than might be expected in an intellectually deteriorated individual. The intensity of an elderly individual's emotional reactions is often strong and spontaneous, although abrupt, disorganized, and not always adequate. Longitudinal observations show that we have to deal only very rarely with one type of emotional reaction or emotional disturbance in an individual. Anger and aggression alternate with fear and restlessness, stubbornness with apathy, psychomotor hyperactivity with periods of tranquility.

Frequently an elderly patient is brought to the hospital in heavy restraint or under heavy sedation. But once on the ward, some of these patients are amazingly quiet, coop-

[1] Based on a paper presented at the Conference on the Clinical Psychologist's Role in Geriatrics, Veterans Administration Hospital, Tomah, Wisconsin, on November 21, 1952. This paper was reviewed and approved for publication by the publications committee of the Veterans Administration, and does not necessarily reflect the opinion of the Veterans Administration.

[2] Senior Physician in charge of geriatrics program, V. A. Hospital, Tomah, Wisconsin.

erative, and sometimes friendly, although their stream of thought is rambling, their speech disconnected, and their orientation impaired. This state of comparative calmness, however, usually does not last long. After a certain time, often independent of the sedation that he is given, he starts to betray little or no understanding for a necessary adjustment to his new environment. But the opposition to an existing order does not imply, by any means, that he has no definite wishes or desires. Thus an elderly patient can be curious; he may start walking about the ward entering rooms where he is not supposed to be; he may wish to wear particular clothes or express ideas that at first glance appear to be disconnected and senseless. I recall one patient who had a desire to wear a red sweater in the middle of the night and no amount of persuasion could divert his attention from this idea; another one wanted to wear his hat on the ward; a third refused to take off his clothes and insisted on going to bed fully dressed; a fourth refused to have a shave in Tomah but wanted to have it in Milwaukee. They may have even more fantastic desires.

In the past these requests were not taken seriously, and the patient had to learn to comply and align himself to the ward routine. To achieve this compliance, some attempts at mild persuasion might have been made, but finally other methods, such as compulsion, sedation, and restraint, had to replace the best intentions of the ward personnel. The latter methods of treatment may solve, in some respects, administrative problems, but not the problems of a psychotic individual. On the contrary, observations made on the wards show that the more a resistant individual is forced to act in a way he resents, the more aggressive is his attitude toward the environment. If, however, it is possible not to contradict him, even to let him have his way, the whole picture may change rather quickly.

Very often major or minor disturbances that remain undiscovered in the elderly psychotic's physical condition are the sources of his restlessness and anxiety. Frequently his inability to verbalize his needs and to describe his subjective symptoms leads to misinterpretations and misunderstandings that are the cause of the elderly psychotic's irritation, impatience, or aggressive attitude. We are often inclined to consider these reactions as expressions of antisocial behavior and miss the real cause of his well-motivated but poorly expressed actions.

Those who take care of elderly patients are rather accustomed to ignoring their inner life. Although understanding an older person is difficult, it is particularly difficult if one is satisfied with the philosophy that an understanding is hardly possible because of the patient's deterioration, which usually includes every aspect of the elderly person's mental activities.

There is no uniformity in the destructive tendencies of the process of deterioration. If the coexistence of well-preserved mental faculties and damaged or destroyed emotional ones is comparatively rare, the presence of well-preserved emotional reactions in an intellectually deteriorated elderly patient is rather the rule. It is amazing how often an orientation on the preservation of emotional faculties helps to establish rapport or some kind of contact with the patient with whom contact would ordinarily be considered impossible. However, since there is little hope of adequately learning about the older psychotic through verbal means, the primary task of the psychiatrist and all persons in the patient's environment, is to learn to understand the language of the psychotic's behavior, and through this behavior—if possible—the motivation that causes his reactions. Experience with elderly persons indicates, for instance, that they are very sensitive to whether or not they are appreciated, accepted, and respected. Their sensitization to other people's behavior toward them has deep roots in the attitudes of society toward elderly persons in general. As a rule it is a negative one(1). Not being capable of eliminating the underlying factors of such an attitude, the elderly individual is looking for such manifestations of other people's behavior that would give him some satisfaction even if only temporary.

The understanding of these and a wide range of other emotional reactions will help to obtain information that is essential in the management of elderly psychotics, particularly those who constitute the hopeless and forgotten segment of many mental institu-

tions. How can a better approach be achieved?

The first step is to listen to the elderly psychotic, to make a serious attempt to understand his speech, and to try to grasp its meaning, if not its content. Our success may be only a matter of degree, but if we do not succeed immediately we shall at least have demonstrated to him that we respect him, and thus eliminate to a certain extent a cause for his possible negative reaction toward the hospital environment and create a better atmosphere for a subsequent improvement in the therapeutic relationship.

No doubt an elderly person can be in a hostile, protesting, and rejecting mood for weeks and months, but his negative and protesting attitude is not a constant phenomenon; it can be changed to a more cooperative and a more constructive one. This is particularly possible under certain circumstances, as, for instance, at a time when the patient becomes acutely ill and is preoccupied with his physical health. Here the therapist may succeed in keeping track of the patient's fears, needs, and habitual reactions.

Should a contact, nevertheless, not be established other emotional channels can be exploited. One example might serve to demonstrate this conception. One elderly patient who was very much hallucinated, seclusive, and resistant, had a painful abcess. He aggressively refused to be examined. After numerous almost hopeless attempts to approach him, a nurse said to him, "Ralph, how about dancing?" Before long Ralph took a comb out of his pocket, combed his hair matter-of-factly, accepted the nurse's suggestion, and they started to dance in the middle of our clinical rounds. Ralph was relaxed, and we succeeded in examining his abcess without any resistance.

But it is erroneous to think that this can happen only on rare occasions. It depends on the degree of our understanding of the patient's behavior. The knowledge of the patient's habits and ambitions frequently gives unexpected opportunities to relieve his anxieties, his resistance, or his opposition.

Any opportunity to demonstrate to a patient that he is not dominated is welcomed, especially in a field that appears to be the exclusive domain of the doctor. If a patient requests a certain drug, or asks to discontinue a treatment he is receiving, an effort should be made to agree with him whenever doing so seems harmless.

These and other observations indicate that rapport or some kind of contact can be established by utilizing the elderly psychotic's longing for acceptance and appreciation. The older psychotic is particularly looking for warmth, devotion, and respect. It was Weinberg(2) who suggested that the attitude toward the elderly psychotic be that of "thoughtful consideration" and "respectful attention" based on sincerity and understanding. Too much interest, however, might be rejected by the patient as well as too little. Not sympathy, particularly not pity, and not antipathy, but empathy, the ability to identify with the patient, opens the way for establishing some degree of contact with him. How one talks or listens to the patient is of importance. As the French say, *"C'est la ton qui fait la musique,"* or, in our equivalent, "Not the words, but the music counts."

In spite of the fact that a considerable number of elderly psychotics are out of contact with reality and seem not to think coherently, there frequently exists the feeling of belonging to a group. If patients are not active or not working, the general feeling toward ward activities will be a negative one. On the other hand, if there is an atmosphere of active participation in ward tasks, there might be a few who would refuse, but many more would gradually become involved in the activities. It is not so much through an understanding of the necessity to be active as it is a desire to be as the others are. This is especially true under circumstances in which the patients are encouraged, and when they feel that their efforts are appreciated.

An attempt is being made at this hospital to develop an approach to treatment of the older psychotics based on these concepts. Without going into details, the new project, which is already in action, will be briefly outlined.

In order to achieve a better contact with the environment the patient should be involved in some kind of activity. This is not simple, but it is possible. It is especially difficult on wards where the elderly individual is rather encouraged to sit around and do nothing. It was felt that the older patient's preserved tendency toward group identifica-

tion could well be utilized and that the negative attitude of the group toward activity could be changed to a positive one. To stimulate this activity a method that is called group occupational therapy is being used.

Group occupational therapy begins on the ward, and consists of group participation in simple mechanical tasks. Every elderly psychotic on the ward has the opportunity to join, to participate, or to quit, within the limits of his physical abilities, without any compulsions or forcing by ward personnel. Among these tasks are polishing the floor, windows, and other objects, and similar cleaning by group projects. Two or 3 times a day the group is in action under the direction and encouragement of the occupational and corrective therapist. The nurse and aides are also involved in the supervising and directing of activities with the idea that they will take over the program on the ward after it is under way and they are sufficiently trained for this purpose.

The polishing, cleaning, and dusting are not new ideas; comparatively new is the concept that this kind of activity be used as part of a program in the active treatment of elderly patients. Certainly any kind of activity has to be adjusted to the patient's physical health, but his general attitude toward activities also has to be taken into account. Here again, not occupation or occupational therapy itself is the goal; the goal is to let the elderly psychotic feel that he is doing some necessary work within the framework of a functioning community. The community can be the ward itself; the specific activity should have the following advantageous characteristics:

(1) It should be conducted on the ward; (2) it should be flexible as far as the patients' participation is concerned; (3) it should be adjusted to the elderly psychotics' physical condition; (4) it should be a simple, usually manual, task which does not require any complex intellectual abilities; (5) it should be such that the results of the energy expended are readily seen, such as the shiny floors in the polishing project, so that interest is stimulated and participation mutely encouraged; (6) it should be performed by a group involving an increasing number of ward patients.

Group work on weaving looms is presently being started tentatively. This is done in rooms where patients must be confined, usually for physical reasons.

The program of activities and plans for the elderly patient consists of several steps. The first is participation in group ward activities. Those who become more accessible and with whom a better personal contact is established are ready, or partly ready, for the next step, which consists of group and individual psychotherapy. If possible, they are then taken to the occupational therapy workshops. The main idea here is to find the field of interest of each individual and to try not only to adjust his abilities to the facilities of the hospital, but also to adjust the hospital facilities to the individual needs of the elderly person. The basis of our relationship continues to be that of thoughtful consideration. Activity is used not for the sake of activity, but is directed toward a goal. Since each elderly patient is considered to have a chance either to be transferred to domiciliary quarters or to be released on a trial visit and, if possible, to be discharged from the hospital, an attempt is made to direct his activities in such a way that he will be able to continue outside of the hospital. In all instances he is being trained to take care of himself and his needs; in some instances his occupation in the hospital may be continued, after he leaves, as a gainful occupation or as a hobby.

When the patient reaches the last stage and is close to the point where he might leave the hospital, the social service department together with the geriatric service contacts the family, institution, or foster home in which the patient is to be placed. No patient is released before more or less satisfactory conditions have been arranged for his stay outside the hospital. The main principle under which we work at this stage is that a personal and social adjustment has to work in 2 directions: in the adjustment of the individual to the environment and also in the adjustment of the immediate environment to the individual.

A training program that involves doctors, nurses, psychologists, social workers, aides, in fact anyone who has contact with the elderly patient, has been planned and already partly instituted. Extension of this program to include family members, guardians, domi-

ciliary officials and personnel, nursing and foster home owners, and other persons who might be interested in the well-being of the elderly patient is also being considered.

The majority of psychotics in the upper age groups suffer from proven or suspected cerebral pathology. We are aware that the treatment proposed tries to find an approach to the elderly psychotic, taking into account the existing, and in the majority of cases, irreversible, pathological condition.

We believe, however, that in contrast to the physiopathological, not all psychological manifestations are irreparable. This program in Tomah is directed toward correcting those psychological changes that either are transient or are the reactions of an already disorganized personality to his environment. It is, of course, complemented by medical and psychiatric screening and treatment whenever necessary and possible. Whether we achieve our goal with a larger or smaller number of patients, we shall at least stimulate, and be stimulated to, further observation that will add to our experience and understanding, and therefore contribute to a better treatment and management of the psychoses in advanced life.

## Summary

1. Mental and intellectual deterioration are typical for psychoses in advanced life. Thus, an approach based on logical argumentation fails to facilitate contact with the elderly psychotic.

2. The emotional sphere is often not so much affected as the intellectual. Therefore, any therapeutic technique in treatment and psychological management of elderly psychotics has to be based primarily on the utilization of preserved emotional faculties, among them the preserved or only partly impaired ability for group identification.

3. Psychological management and treatment based on these principles is divided into the following 4 phases: Group occupational therapy; group and individual psychotherapy; training in self-care both inside, and in case of release, outside the hospital; adjustment of the elderly psychotic to the environment and adjustment of the immediate environment to the elderly person.

4. This program, which is already in action, takes care of the reversible psychological symptoms but not of the irreversible pathophysiological ones.

5. Although still in an experimental stage, the program opens the way for a more satisfactory management of elderly psychotics. The use of the methods described has therefore been advocated.

## BIBLIOGRAPHY

1. Ginzberg, R. The negative attitude toward the elderly. Geriatrics, 7: 297, Sept.-Oct. 1952.

2. Weinberg, J. Psychiatric techniques in the treatment of older people *in* Growing in the Older Years. Edited by Donahue and Tibbitts. University of Michigan Press, Ann Arbor, 1951.

# PSYCHIATRY AND MENTAL HYGIENE IN SHANGHAI[1]

## Historical Sketch

CHARLES HART WESTBROOK, Ph. D.,[2] Richmond, Va.

In China, the several phases of the psychiatry and mental hygiene movement were largely of spontaneous, local, and independent origin. As the science of psychiatry developed and popular knowledge of its accomplishments spread, the efforts became more deliberate, widespread, and organized. Confidence in the modern medical profession gradually began to undermine the old faith in the native art of medicine and in its practitioners.

Dr. John Kerr, in 1898, initiated this movement by founding the Institution for the Insane at Canton. The first course of lectures on mental diseases accompanied by clinical teaching was presented about 1905 in the College of Medicine at Hongkong(1). From the South, the movement spread to Peking in the North, and thence to the Soochow-Shanghai-Nanking area of east China; in the late 'thirties and early 'forties, during the Sino-Japanese and Second World Wars, it extended through central China out to Ch'eng-tu in the far West. Upon the conclusion of World War II in August 1945, those who had carried the new specialty to the West resumed their professional activities in Shanghai and Nanking(2).

Psychiatry was in its earliest educational stage in metropolitan Shanghai, China's largest city, at the time of the destruction of Greater Shanghai by the Japanese in February and March of 1932. The estimated population in 1931(3) was more than 3 million. With the large influx of refugees, the number increased from over 3.7 million in 1936(4) to approximately 5 million by the end of 1937. Paralleling the serious economic problem of these years was the staggering practical problem for general medicine, psychiatry, and mental hygiene. This challenge was met by great progress in these sciences during the decade of 1932-42, blocked only by the restrictions of the Japanese occupation after the spring of 1943.

Shanghai's insane were first kept in St. Joseph's Hospice, an asylum-like institution, where they received little professional care, were kept chained and lying on the floor, as witnessed by the outstanding pioneer in psychiatry, Dr. F. G. Halpern, upon her arrival in Shanghai in 1933(5). The Russian community also maintained a small mental home, conducted by Dr. A. Tarle, for Russian refugees. Usually, however, mentally disordered persons were kept in their homes; the general public was not aware that they could be treated and should be brought to a physician(1).[3]

### Training Program

First to recognize the urgent need for training Chinese physicians in psychiatry was Dr. F. C. Yen, director of the National Medical College of Shanghai. On his invitation, Dr. R. S. Lyman, a graduate of the Johns Hopkins University School of Medicine, lectured on neurology and psychiatry at the National Medical College and used cases for demonstration purposes during the 1931-32 school year. He also engaged in research with Dr. J. R. B. Branch on brain-injured Chinese casualties of the resistance to Japanese attacks upon Shanghai in 1932. Dr. Barrie succeeded Dr. Lyman the following year when he joined the faculty of the Peking Union Medical College. In 1933, Dr. Fanny G. Halpern,[4] a medical professor at the University of Vienna, was appointed

[1] From the Department of Education and Psychology, University of Shanghai, Shanghai, China.
[2] Professor of Psychology and Education, University of Shanghai.

[3] It is noteworthy that during this period the Elizabeth Blake Hospital in Soochow had a psychopathic ward in operation. Opened in 1923 under the direction of Drs. L. S. Wang and M. P. Young, it rendered valuable service until its enforced closure late in 1937 owing to the Sino-Japanese War.

[4] Deceased June 28, 1952, Vancouver, B. C. Dr. Halpern studied with Drs. Jaurec and Alfred Adler in Vienna and became a member of the neurology and psychiatry teaching staff of the Medical School of the University of Vienna.

professor of neurology and psychiatry at the National Medical College and charged with the responsibility of developing this pioneer work(6). Thus, at Shanghai modern psychiatry was first introduced into east central China, and later that city became the most active center for the development of the mental hygiene movement in China.

In 1934, Dr. Halpern began teaching regular courses in neurology and psychiatry. She organized a division of neurology in the first hospital of the Red Cross Society of China, the teaching hospital of the National Medical College. That same year she started special undergraduate and postgraduate courses for the training of psychiatric nurses. These were attended not only by students of the National Medical College but also by those of the Medical School of St. John's University and the Women's Christian Medical College, of which Dr. Josephine C. Lawney was director. These 3 medical schools in Shanghai and the Peking Union Medical College were the only ones in China offering regular courses in psychiatry as late as 1934(2).

## First Psychiatric Hospital

In June 1935, the Shanghai Mercy Hospital for Nervous Diseases was opened at nearby Ming-Hong. Dr. Halpern, supported by the Reverend Father Schulz of the Steyl Missions, had convinced Mr. Loh Pah-Hong, president of the Catholic Action and prominent Shanghai philanthropist, of the great need for a modern mental hospital in China. Under his leadership China's first psychiatric institution was financed by philanthropic circles and contributions from the city government of Greater Shanghai, the Shanghai Municipal Council (International Settlement) and the French Municipal Council(6). It has a capacity of 600 beds, modern equipment, and 11 buildings forming a pavilion system with a church at the center.

Dr. Halpern was appointed medical director of this history-making institution. It became the teaching hospital of the National Medical College; the Foreign Mission Sisters of St. Dominic of Mary Knoll and the Brothers of Charity from Trier, Germany, became the nursing staff. Overcoming such major difficulties as the lack of trained Chinese medical and nursing personnel, the still deeply-rooted native superstition and unscientific approach to the care of mental patients, and the lack of adequate legislation, Dr. Halpern succeeded in introducing modern care and therapy in an up-to-date institution. Patients were soon arriving from the whole of China and the Far East(2, 5, 6).

Thereafter, this intrepid pioneer lectured widely, organized study groups, and addressed scientific, educational, religious, social, and charitable groups, disseminating information, influencing public opinion, and promoting preventive and remedial methods. Professional interest in psychiatry received new interest and became nationwide. At the third biennial conference of the Chinese Medical Association at Canton in November 1935, she presented a paper on problems of psychiatry in China, from medical, social, and legislative viewpoints. She then offered a resolution, seconded by Dr. Seldon of the Canton Mental Hospital, and passed, that brought about the creation of a Committee on the Problem of Psychiatry in China to study the following areas: (1) education in psychiatry for medical and nursing students, as well as postgraduate training for physicians; (2) the need for psychiatric institutions in China with a view to converting the asylum type into a modern hospital for mental diseases; (3) preventive psychiatry and mental hygiene, promoting courses in psychology for teachers, child guidance clinics, schools for feeble-minded children, training for psychiatric social workers, and psychotherapy clinics; and (4) legislation to amend the Chinese civil and penal codes pertaining to insanity and mental aberrations, including legislation on admission and discharge of patients committed to a mental institution, the question of "responsibility," and psychiatric expert testimony in courts(7).

Specialists from different parts of China made up this committee. Dr. Yen was chairman and Dr. Halpern, secretary. At its first meeting in February 1936, the initial step was taken toward drafting legislation relating to insanity for presentation to the Nationalist Government. A special committee, consisting of Drs. Halpern, K. F. Suen, and H. P. Chu, and 2 lawyers, Drs. F. Lin and C. Fisher, was assigned this important task. Unfortunately,

the outbreak of the Sino-Japanese War in 1937 prevented completion of this ambitious program as it required regular contact with other parts of China(8).

When the Chung Shan Memorial Hospital became the new teaching hospital of the National Medical College, the neurologic wards were transferred from the Red Cross Society's Hospital to the new location. In the old quarters Dr. Halpern established psychiatric wards for the Red Cross Society.

## Mental Hygiene

In her tireless efforts to promote mental hygiene, especially from 1935 onward, Dr. Halpern was assisted in the work among women's groups and clubs by Florence J. Sherriff, Ph. D., professor of history and political science at St. John's University. Later, it was my privilege to cooperate by participating in contacts and programs with educational organizations and in the development of students' interests in clinical and personality psychology and mental hygiene.

In an address on May 19, 1938, before the Club Institute of the Joint Committee of Shanghai Women's Associations, as part of an all-day program devoted to "Mental Welfare in Shanghai"(9), Dr. Richard Wang pictured psychiatry's rapid progress in China:

> As a Chinese physician, I wish to give you a bird's-eye view of what has already been accomplished. . . . (1) Five years ago, in all East and Central China there was not a single medical or nursing school where a regular course of treatment for mental and nervous diseases was given. (2) The institutions for the mentally ill were still of the asylum type. (3) Simply nothing of preventive work in psychiatry or (4) about legal Codes concerning mental patients, existed. . . .
>
> Today, (1) we have . . . courses in neurology and psychiatry . . . in the Shanghai Medical Colleges. (2) Some Chinese physicians are now interested in specializing in this line, and (3) a modern mental hospital (Mercy) has been established. . . . Five years ago, on Dr. Halpern's arrival in China, (4) no staff was available to assist her in clinical work; but now we have a staff of well-trained Chinese physicians and nurses, graduated in successive years. . . . (5) We have introduced the most modern, scientific therapy—the same as that used in other modern countries. (6) Educational campaigns of 4 years past have taught the Chinese the necessity of sending to mental institutions the insane patients, formerly either left in chains at home, among nursing mothers and little children, or sent to Buddhist monks, to live in their temples —or elsewhere to one of their 101 sects.
>
> (7) Another advance is that Chinese physicians now frequently request consultations with psychiatrists. . . . (8) A child guidance clinic in our division at the Red Cross Hospital was recently taken in charge by us psychiatrists from the National Medical College. . . . (10).

## The Committee on Mental Hygiene of Shanghai

This Committee came into being on June 29, 1938, as an outgrowth of the Committee on Mental Welfare of the Club Institute of Shanghai, organized on June 17 of that year, and enlarged to include representatives of groups other than women's clubs. Its first officers were: chairman, Prof. Ho-Ching Ch'en, Chinese Education Officer, Shanghai Municipal Council; secretary, Dr. Sherriff; and treasurer, Mrs. H. J. Van Hengel of the Young Women's Christian Association. Acting as a special committee, Dr. Halpern, Dr. Sherriff and I planned a program of training and activities, started a training class promptly, and drafted a constitution and bylaws, which were adopted on July 13, 1938. The objectives set forth in the constitution were:

> Article II. Purpose. The purposes of the organization shall be: (1) To educate the general public in Mental Hygiene through courses of study, radio talks, lectures, and the dissemination of information through magazines, newspapers, and other publications; (2) to improve the Mental Welfare of children by education of parents and teachers, and to care for and treat problem-children and feeble-minded children in and through Child Guidance Clinics, and by the establishment of special institutions; (3) to care for the Mental Hygiene of convalescent patients discharged from Mental Hospitals, and to assist in the treatment of minor nervous ailments, neuroses, drug and alcohol addictions, and antisocial behavior, through psychiatric social work and psychotherapeutic clinics; (4) to ameliorate the conditions of caring for patients in hospitals for the insane; (5) to conduct psychiatric social work in the hospitals; (6) to inaugurate, to conduct, and otherwise to assist in, the promotion of any other plans or methods for the improvement of psychological conditions of living, as may be deemed advisable(6, 11).

This committee was later recognized by the Chinese Medical Association as a subcommittee of its Committee on Psychiatry. One of its earliest projects was the training of nurses, teachers and laymen as psychiatric aids. Dr. Sherriff served as educational director of the first classes of nurses given psychiatric training by Dr. Halpern at the

International Young Women's Christian Association, and Alice Gregg, Ph. D., lecturer on Psychology at St. John's University, also taught an introductory course in general and educational psychology for volunteer applicants. Dr. Halpern's 14-week course on psychopathology and mental hygiene, with observations at the Red Cross Hospital, had 70 registrants, some 50 of whom became available to give aid when needed.

Another project of the Committee on Mental Hygiene, undertaken by a subcommittee on feeble-mindedness, was segregation of the particularly dull and feeble-minded children from the fifty-odd war-refugee camps in order to evaluate their individual abilities and needs and develop appropriate remedial methods. The committee consisted of the chairman, Dr. H. S. Ch'en of the Chinese Education Testing Division, Shanghai Municipal Council's Schools, 4 other psychologists, Profs. Ho-Ching Ch'en, Y. C. Chang, Eugene Shen and I, and Dr. C. T. Ho, director of the China Vocational Education Association. Before this cooperative educational endeavor could be put into operation, the camps were broken up, and the refugees, largely from rural areas, returned to their homes.

The appointment on March 8, 1939, of a committee on mental hygiene clinics, headed by Dr. Halpern, resulted in the opening of Shanghai's first mental hygiene clinic in January 1940 in St. Luke's Hospital No. 1 of the St. John's University Medical School. To prepare a small group of mature volunteers for service in the proposed clinic, in the spring of 1939, I taught a course titled "Intelligence Tests, with Demonstrations and Practice Testing." Dr. Sherriff, who served as educational adviser and secretary, was among the 6 persons who qualified to administer the Stanford-Binet Tests (1937 Forms) revised by Terman and Merrill(12) as well as the fundamental form-board tests. Prof. H. C. Ch'en cooperated by presenting a demonstration of his own group intelligence tests and educational tests at one of the Shanghai public schools.

After spending 6 months in England and the United States inspecting mental hygiene clinics and training institutions, Dr. Halpern returned to Shanghai in December 1939 and from the outset became director of the new clinic and head of the division of medicine and psychiatry. The division of psychology and mental tests came under my direction, as did the supervision of the division of educational guidance, with Dr. Sherriff serving as adviser. The division of psychiatric social work was assigned to Dr. Constance Cater, who was in charge of similar work in Lester Hospital, and that of recreation and play to Mrs. Joseph Brown. In addition to duties at the clinic, the staff cooperated with schools, camps, and charitable organizations; volunteers started social work in jails; and students majoring in education undertook the teaching of retarded children.

### Mental Hygiene Association

In May 1940, reorganization of the committee on mental hygiene, under the name of the Mental Hygiene Association of Shanghai, was effected. The work was thereby broadened to cover metropolitan Shanghai, including the International Settlement, the French concession, and the greater Shanghai municipality; and the change resulted in greater cooperative effort and financial support. It was my privilege to head this new organization; the other executive officers were Mr. Hwang Chia-Yin, an editor of the popular Chinese magazine *West Wind*, as vice-president, and Dr. Halpern, director of the Bureau of Mental Hygiene.[5] The broad educational and promotional activities, participated in by physicians and educators and presented in both Chinese and English, aroused keen interest and proved constructive. Results were reflected in several universities where intelligence and educational testing, and general, abnormal, clinical, personality and experimental psychology had been increasingly taught; curricula were enriched through correlation of these subjects with sociology, cultural anthropology, child development, and clinical psychology.

A project of the child guidance clinic of

[5] Additional members of the executive committee were Prof. J. H. Pott, head of the psychology department, St. John's University; Miss Li Djoh-I, social service department, Shanghai Municipal Council; and the Rev. Ting Kwang-Hsün, secretary of the Chinese Young Men's Christian Association.

practical value for use with refugee German children, and Jewish problem children using German speech, was the adaptation and the translation into German of Terman and Merrill's revision of the Binet-Simon Intelligence Tests(12). Both forms, L and M, were prepared.[6] Also, Form L of the same tests [7] was adapted and translated into Chinese (Mandarin).

### War's Blight in the Forties

After 1940, when the Sino-Japanese War necessitated evacuation of the clinical students from the National Medical College to K'unming in southwest China, Dr. Suh Chung-Hwa continued the psychiatric work in the Red Cross Hospital. About the same time, Dr. Halpern accepted a professorship in St. John's University and established a neurological and psychiatric department in the St. John's Medical School, with neurologic and psychiatric wards in St. Luke's Hospital No. 1, the St. John's teaching hospital.

Dr. Halpern also established neurologic and psychiatric wards in the hospital of the World Red Swastika Society, a Buddhist charity organization. This was changed in 1939 from a general hospital into the Therapeutic Institute for Nervous and Mental Diseases. These wards, supervised by Dr. Li Bang-Cheng, became the teaching hospital of the St. John's University Medical School, with Dr. Halpern as psychiatrist-in-charge, until the transfer of the psychiatric wards to the St. Luke's Hospital No. 1 in June 1940. These 2 hospitals also cooperated closely with the Mental Hygiene Association; the Institute provided space for the clinic upon its transfer from the original location in St. Luke's Hospital.[8] That same year, Miss T'ang Ching-Chung established at the Institute a nursing school, with special emphasis on psychiatric nursing.

Late in 1943, after the Japanese had occupied all of metropolitan Shanghai, the Mental Hygiene Association was obliged to cease functioning. In June of the next year, both the Therapeutic Institute and St. Luke's Hospital No. 1 were forced to discontinue their normal professional activities. Furthermore, the latter institution was requisitioned by the Japanese for a "Civic Assembly Center's Hospital," that is, to function as an internment camp hospital for Westerners. Much earlier, they had closed St. Luke's Hospital No. II.

After V-J Day in August 1945, a psychopathic ward directed by Dr. Suh Chung-Hwa was opened in the private Hungjao Sanitarium, which provided a clinic for group treatment of its mental patients. Also, the Mental Hygiene Association attempted to re-establish its previous activities, but the departure of many of the trained personnel prevented resumption of any extensive work. Certain members, however, were again invited to lecture before various organizations. In 1948, a child guidance clinic, sponsored by the Shanghai Community Church, the Shanghai Advisory Committee for Child Welfare, and Boys' Town, came into existence shortly before the Chinese Communists took Shanghai.

### ACKNOWLEDGMENT

Appreciation is expressed to Dr. Florence J. Sherriff, now of Wesleyan College, Macon, Ga., for her assistance in the preparation of this historical record and for her kindness in reviewing the manuscript.

[6] Dr. Felix Gruenberg (M. D., Vienna), resident psychiatrist at the Therapeutic Institute for Nervous and Mental Diseases, made the German translations and also generously served as German interpreter in the handling of cases. In preparing the translations, he was assisted by Mrs. Elly Weinberg, M. A., German Department, St. John's University, and had my assistance as consultant.

[7] Under the direction of Prof. Li Hao-San and myself, Miss Grace Siu-Yin Ch'en in 1941 translated into Chinese and adapted Form L as her thesis for the B.A. degree at the University of Shanghai. In 1950, she received the M.Ed. degree at the University of Virginia, where she is now seeking the Ph.D. degree.

In the clinic, most of the testing of Chinese children was done gratuitously by Mrs. Kiang Yao Hsien-Hwei, B.A., later a graduate student of Crozer Seminary and the University of Pennsylvania.

[8] On June 22, 1942, the first biennial report of the clinic was made, and the following officers were elected: president, Principal T. Y. Hu of the Chinese School for Boys of the Shanghai Municipal Council; vice-president, Bishop B. S. Yü of the Episcopal Church (Sheng Kung Hwei); secretary-treasurer, Dr. Peter Mar of the Chinese Medical Association; and director of the clinic, Dr. Halpern.

## BIBLIOGRAPHY

1. Wong, K. C. A short history of psychiatry and mental hygiene in China. Chinese M. J., **68**: 44, Jan.-Feb. 1950.

2. ———. A short history of psychiatry and mental hygiene in China (in Chinese). Chinese M. Hist. J., **111**: 4, Dec. 1951.

3. The China Year Book, 1931-1932 (Ed., H. G. W. Woodhead), p. 3, Shanghai, North China Herald, 1932.

4. China Handbook, 1937-1945 (revised and enlarged with 1946 supplement, editor-in-chief, H. K. Tong), p. 614. Toronto, Macmillan Company, 1947.

5. Halpern, F. G. Care of the insane in China. Inaugural address at the opening of the Shanghai Mercy Hospital for Nervous Diseases, June 29, 1935.

6. ———. Personal notes on the Shanghai Mercy Hospital for Nervous Diseases.

7. ———. Problems of psychiatry from medical, social, and legislative viewpoints. Report of Committee on Psychiatry, Third Biennial Conference, Chinese Medical Association, Canton, Nov. 1-8, 1935. Proceedings abstracted, Chinese M. J., **49**: 1333, Dec. 1935.

8. Shanghai Medical News, **II**, 9, 1936.

9. Club Institute of the Shanghai Women's Associations, Shanghai, China. Program of topics and speakers for session of May 19, 1938.

10. Wang, R. A history of mental welfare in Shanghai. Address at Club Institute of Shanghai Women's Associations, May 19, 1938.

11. Mental Hygiene Association of Shanghai: Constitution and By-Laws. Shanghai, China, July 13, 1938.

12. Terman, L. M., and Merrill, M. A. Measuring Intelligence: A Guide to the Administration of the New Revised Stanford-Binet Tests of Intelligence. Boston, Houghton Mifflin Company, 1937.

## COLLATERAL READING

1. Halpern, F. G. Notes on Medicine, Including Neurology and Psychiatry (compiled and edited by her students of the National Medical College of Shanghai). Shanghai, Chiu Yih Book Company.

2. Hume, E. H. Doctors East, Doctors West: An American Physician's Life in China. New York, W. W. Norton & Company, 1946.

3. Latourette, K. S. A History of Christian Missions in China, pp. 268-269, 452-465, 561-562, 652-656, 759-761, 788-790. New York, Macmillan Company, 1929.

4. Sues, I. R. Shark's Fins and Millet, pp. 100-102. Boston, Little, Brown & Company, 1944.

5. Williams, S. W. The Middle Kingdom, Vol. II, pp. 333-340, Ed. 3. London, W. H. Allen and Company, 1883.

6. Wong, K. C., and Wu, Lien-Teh. History of Chinese Medicine. Shanghai, Kelley and Walsh, 1920. (Standard history of medicine in China.)

# CLINICAL NOTES

## THE USE OF PERMANENT SOLUTIONS OF SODIUM AMYTAL AND SODIUM SECONAL

DAVID C. ENGLISH, M.D., AND RUDOLF LEISER, M.D.[1]

The clinical value of permanent solutions of sodium amytal and sodium seconal was investigated on 105 patients in the psychiatric department of the Wayne County General Hospital, 75 patients receiving a total of 220 injections of sodium amytal solution and 38 patients, 100 injections of sodium seconal solution.

Since sodium amytal forms an alkaline solution with water, which gradually decomposes, parenteral sodium amytal has been dispensed heretofore as a powder in an ampoule with an accompanying ampoule of water, the 2 being mixed immediately before use. It has been the experience with a great number of clinicians that the effectiveness of the solution decreased rather rapidly after its preparation. In addition, very valuable time is lost in emergencies in preparing this solution. Another disadvantage of this sodium amytal powder is that it can be dispensed efficiently only in arbitrary dosages, *e.g.*, multiples of 3¾ grains; if a dose not a multiple of 3¾ of sodium amytal is to be used, the unused part of the drug has to be thrown away since the solution is unstable.

A new product, not yet released for general use, does not have the above mentioned disadvantages; it contains sodium amytal in permanent solution form, in a special glycol-water base, 3¾ grains of sodium amytal in 5 c.c. of solution. This product will be dispensed in 5 c.c. ampoules and 30 c.c. bottles, the latter permitting the efficient selection of any desired dosage. The solution is supposed to be stable for 18 months. It can be placed into a syringe without any preliminary mixing and is ready for use at any time later, as long as the needle and the syringe are kept sterile.

The injection of permanent solution of sodium amytal did not reveal any side effects either local or general. The intravenous action of both products is identical. In intramuscular use, the glycol solution seemed to take effect more slowly than the usual aqueous solution but the total effect was the same. Only 5 c.c. of material should be placed in any one injection site, so that the use of 7½ grains means 2 separate injections. Because of the glycol the new material is "oily." However, it is infinitely miscible and soluble with water in all proportions and can easily be removed from hands or clothes.

Sodium seconal has also been prepared in identical strengths in a similar solvent, and was released last month for general clinical use. This product has been used on 30 patients with excellent results. At first it was thought that the duration of action of parenteral seconal would be too brief for nocturnal hypnotic use on disturbed patients. However, in the clinical trials it worked well. Direct comparisons were made between sodium amytal and sodium seconal on 5 patients, alternating the drugs on successive nights: 4 patients slept better and longer with seconal and the fifth had equal results from the 2 drugs. Three and three-fourths grains of sodium seconal appeared to have an equivalent effect of 7½ grains of sodium amytal.[2] The parenteral seconal hypnotic effect lasted 5 hours even in extremely disturbed males.

[1] From the Department of Psychiatry. Dr. Rudolf Leiser, Director. Wayne County General Hospital, Eloise, Michigan.

[2] The Eli Lilly Company generously supplied the above mentioned products.

# PRESIDENT'S PAGE

Last month a statement was made about the organization of The American Psychiatric Association, the new development in the form of the Assembly, and provision for further growth and responsiveness through the guidance of the Commission on Long Term Policies. The importance of internal communication in our Association was stressed. An appeal was made for more member participation.

In October, Council and Committees will meet with as many committee members present as the budget will allow—and, by the way, this matter of budget is an important one. Work must be done through committees. Interest in committee work can be aroused and maintained by meeting together informally, as at the October meeting, without pressure and distraction. This requires money. With increasing committee activity, more money is required to keep vital currents flowing. Is there any way of getting more money for committee meetings? Have you suggestions?

The October meetings will consider problems of immediate importance to the Association. If you have anything on your mind —criticisms, questions, suggestions—write to one of the officers, a committee member you know, or the chairman of a committee. Here is an opportunity for you to do something and make your thoughts heard. The meetings of Council and Committees in October should be of increasing importance in the future of the Association. They are wholly devoted to the interests and business of the A.P.A. There are not the distractions of professional papers and social occasions, however important these are, as in the case of the annual meeting.

At Los Angeles, both before the Association, when the new President was introduced, and before the Assembly, as a sort of inaugural program I emphasized three subjects which I think are important for the Association and for which I intend to work during my presidency. (1) Tap the interests, thoughts, energy of the younger men in the A.P.A.—resources we are largely neglecting. (2) Appeal to the American Psychoanalytic Association for increased contribution to the work of public mental hospitals. Tap the resources of energy, of intellect, of favorable economic position, of members of the American Psychoanalytic Association to extend their insights into the concrete clinical work of psychiatrists doing psychotherapy in the public mental hospitals. (3) Improve our relations with our medical colleagues—especially the general practitioners and family doctors.

The following thoughts occur to me as ways and means of stimulating and facilitating participation of younger men in the activities of the A.P.A. I believe that any young member could write to a committee chairman—a committee which represents an area of interest for him—volunteer to do some work, and undertake an assignment. Chairmen of committees, whether national or local, would welcome such interests and be glad to accept such help. Have you any thoughts along this line? There are many projects in which help and work *are* needed. This is a practical way of making yourself felt and of contributing to your profession. It is a way of moving into the activities of the A.P.A. If you have an impulse to participate, don't wait! There is no time like the present. I believe work can be done, contributions made, even without formal membership in a committee. Could we not establish a Corresponding or Associate Membership to our committees? Dr. David Flicker has already written in some suggestions about this, and these will be presented to the Council. Have you any suggestions?

Then there is the problem of increased communication in the interest of better functioning of the A.P.A. Communication can come through an annual meeting, but that is only once a year. It can come through the publication of proceedings which are, of necessity, abbreviated and delayed, so that some of the vitality is lost. A President's Page in the JOURNAL can attempt to keep the

membership informed once a month of some of the things that are in his mind. The A.P.A. Newsletter is a most successful channel of communication—something to read, brief and trenchant. But personal contact is an important mode of communication which, it seems to me, we could use more often in the Association. We should make it possible for officers to do more traveling. The voice and appearance of an officer adds warmth and vividness. It can personalize the Association. The Medical Director does a remarkable job in the amount of ground he covers. The President is expected to travel and speak, but there are many obvious limitations to one man's activities. No matter how great his good will there are limits to capacities.

I raised the following question with Dr. Henry Brosin, who is Chairman of the Nominating Committee. (It more properly should have been addressed to the Commission on Long Term Policies. But it is difficult for me always to think of protocol. A problem strikes me, and the people who are working with it come first to mind.) Of course, the problem I am raising cannot be solved by the present Nominating Committee. It will take thought and consideration by the whole membership over some period of time. I asked Dr. Brosin why we should not have two presidents. This theoretically should divide the burden and increase the function. There are more requests for speaking and meetings than one man can possibly fulfill. Perhaps this is one of the raisons d'être of vice-presidents in organizations. Would it be helpful also to have a vice-president or two? My mind is searching for a type of arrangement which will better meet the problems we are considering. The Episcopal Church has solved this problem by having Bishops, Coadjutors and Suffragan Bishops. It seems to me we need more top personnel who could keep in closer personal touch with local societies.

I have mentioned the possibility of having two presidents who could share the administration and policy-making problems of the Association—one, say an Executive President, the other, an Associate or Honorary President. The one could take care of the "honors," the amenities, the social side, the tradition, and traveling—the interpretation of policy. The other could concentrate upon development, organization, new ideas. One could be the idea-man; the other could be concerned primarily with liaison, social tradition, and interpretation. England has solved this politically with the Premier and the Sovereign.

Another advantage of this sort of arrangement occurs to me. There are always a number of men in our Association who should receive signal honor. They are elder statesmen, whom we all respect. In the press of circumstance, they have not been elected president. There is not enough time to take care of all of those whom we wish to honor. In the minds of all of us names of such persons in our Association occur. Can we develop some turn or future of organization which will enable us specifically to honor those whom we should honor? Having such an additional person or position, whatever the name, to turn to each year would add to our resources, our communications, our energies.

The idea of having two presidents is only an exploratory thought on my part, which comes in response to the need for more personal contact and of cohesiveness in our Association. What is your reaction to all this?

KENNETH E. APPEL

# COMMENT

## PSYCHIATRY AND EUPHEMISTIC DELUSION

As soon as man started to live in houses rather than caves, he built a structure in the back to serve as a latrine. This was called simply a "back house." Rapidly the phrase "back house" became socially indelicate, so a new word was coined:—"privy." Here was a respectable word, usable in mixed company. But soon "privy" became a dirty word. At about this time, they were moving these facilities right into the home, a change made possible by the development of plumbing. This provided the new word, "water closet." Here was a neutral phrase, made up of two ordinary English words neither of which had any indelicate connotations. The phrase "water closet" was expected to remove the unpleasant associations that had somehow become adherent to the once acceptable word "privy." And so it did—for a very short time. But then "water closet" attracted to itself the socially nonacceptable implications of its predecessor. This time the lexicographers really made a bold change. They took a word from French, that most elegant of languages; it was a word that had only the pleasantest connotations for it meant "good grooming." That was the word "toilet." Yet within two decades of its introduction the word "toilet" had to be banned from polite society. It was replaced by "lavatory" as a nice scientific term for a place where one washed. As this world fell into bad company it promptly gave way to "bathroom," which by definition was surely the opposite of a dirty word. This so swiftly acquired the same connotations that now one is surprised if the purpose of visiting a bathroom is to take a bath. The latest word in this parade has been but recently launched and today no new house is complete without a little space on the ground floor marked "powder room" in the architect's plans. The quest for a euphemism failed. Each new word rapidly acquired that precise shade of meaning that the phrase-makers were trying to avoid.

A similar hunt for euphemism has characterized psychiatry since the turn of the century. The stigma was always in psychiatry, never in neurology. There was no disgrace in having a brother who had Bell's Palsy or a mother with sciatica. Since (until recent times) the marriage of neurology to psychiatry was a happy one, it was felt that by calling the specialty "neuropsychiatry," it could be made respectable. Entering the office of a "neuropsychiatrist," a patient would not be assumed to have a mental aberration. Perhaps all he had was shingles. The prefix "neuro" would thus rescue the psychiatric patient from the stigma. To disguise it still further, it became the fashion to use the abbreviation "NP."

But the hope was doomed. Today, if you say that Elmer is an NP patient, the man in the street assumes that Elmer is crazy. Instead of the N making the P respectable, the reverse has happened: the P has contaminated the N. This reached its apogee on April 20, 1953, when the President of the United States, by Executive Order 10,450, acknowledged the stigma that had thus been attached to neurology. A newspaper release listed factors that might be considered in branding a Government employee as a poor security risk. One of them was "treatment for a serious neurologic disorder." Thus "neurologic" had finally acquired all of the unhappy implications of "psychiatric." The attempt to take the curse off "psychiatric" by diluting it with "neurologic" had backfired.

So with the replacement of "mental disease" by "emotional illness"; "commitment" by "certification"; "parole" by "visit." So the old "nervous disease clinic" became first a psychiatric clinic, now a mental hygiene clinic. Always the hope of sweetening the concept by changing the word; always the old stigma contaminates the new word much more readily than the new phrase lends respectability to the old concept.

The word "psychosis," for instance, was once an obscure word that meant any mental aberration. It was then promoted as an in-

offensive synonym for insanity. The hope was that no one would feel stigmatized by such a pleasant sounding word. Furthermore, "psychosis" belonged in the arcane lexicon of the medical specialist and was unfamiliar to the average layman. Fifty years ago, indeed, the professors made valiant efforts to persuade medical students and practitioners to say "psychotic" instead of "insane," promising that families, and the general public, would accept this with equanimity, whereas they would recoil at the harshness of the word "insane."

Did it work? It did not. Before long the very prefix "psycho–" became a frightening one. By itself, "psycho" was to become a word of contempt. It got so bad that dermatologists were afraid to tell a victim of barber's itch that his condition was "sycosis vulgaris." By a strange irony of lexicography, they could not give him the official synonym either, for that was "mentagra."

During the war, I was in the Southwest Pacific. Reluctant to brand soldiers with the "psycho" implications of the word "psychoneurosis," we looked about for some less stigmatizing phrase. With our limited time and facilities, we were not sure that many of these soldiers actually did have psychoneurosis. All we really knew was that in the unpleasant climate (meteorologic, psychologic, and military) of the South Seas, they had developed emotional reactions. Colonel S. A. Challman, the theatre psychiatrist, suggested that we take out of mothballs the official, but little used phrase, "Simple Adult Maladjustment." The phrase was unfamiliar to laymen; it described what happened without attaching any deeper implications. And as it bypassed that frightening phrase "psycho" the patients would not feel stigmatized. We used the "Simple Adult Maladjustment" diagnosis as extensively as we honestly could. Did it remove the stigma? It did not.

One night during a moving-picture show in New Guinea we heard the men burst into laughter as the film hero displayed an obviously hysterical symptom. "He's just a Sammy" was the call from many parts of the big tent. "What," I asked later "was a Sammy?" One of the patients explained. It stood for "Sam" he said, and—he added confidentially, "Sam was the Army's code word for a nut." And why "Sam"? They were the initials of "Simple Adult Maladjustment." Enough men had seen that phrase somehow on enough clinical charts to brand this once neutral expression with all the connotations of "psychoneurosis" and "psychosis."

The development of the phrase "back ward section" into "chronic section" and then into "continued treatment service" is another illustration. Each change was supposed to take away the defeatist implication of the previous phrase. The word "chronic" was originally associated with "mild" because of the popular idea that "acute" meant "serious." (As it still does in political thinking when we say that the situation in the Far East—or Near East—is acute.) But in a short time families attached to the label "chronic" all of the connotations of "back ward." Hence, the switch to "continued treatment." Here the thought was to emphasize the "treatment" aspect of the case. The really unpleasant feature of "chronic" was the implication that it was "untreatable." The phrase "continued treatment" was to take the edge off that fear, because it would emphasize "treatment." Now this new phrase has become a token of despair. Families believe that "continued treatment" means "forever sick." So today we are searching for yet another phrase to scatter some pleasant incense over "continued treatment."

These euphemisms fail because sooner or later (usually sooner) the real meaning penetrates the verbal coating and attaches itself to the new phrase. In desperation some have suggested that we abandon words entirely and use numbers or arbitrary symbols to classify our patients and our procedures. This, it is suggested, would make it impossible to attach any stigmatic meaning because a number produces no emotional response.

This won't work either. During the war, the neutral phrase "4F" acquired an entire battery of special emotional connotations. The Army's famous "Section 8" was only a number: simply 1 of 12 ways of getting out of the Army. But "Section 8" was transmuted by the folk law into "8-ball." You could then scorn a man by giving him a number, 4F or 8-ball, quite as effectively as by calling him a "psycho." The fact that psy-

chotics were *not* discharged by way of Section 8 did not seem to make any difference. A hundred million people thought otherwise and that meaning was welded on to the number "8," a meaning which no amount of education or explanation could alter.

Perhaps it is better to devote our energies to something more constructive than terminological witch-hunting. The simple word that honestly describes the disorder, the patient, or the process, may cause a brief shock to the family or to the patient himself. But to use an unctuous and inaccurate token-word is futile. The layman soon discovers its real meaning. We are worse off than if we had used the more honest term, for the family and the community then charge that we have tried to mislead them.

Suppose, for instance, parents object to the release of a patient from the hospital. They have adjusted to living without him. They fear he will do strange things. "He's mentally ill—or emotionally disturbed—" they say, "and therefore he should be kept in the hospital. Why can't you hold him against his will?"

If you adhere to the euphemism you are tied up in double talk. "We can't hold him against his will." "But he's emotionally ill, isn't he? And isn't that what you do in this hospital? You hold hundreds of emotionally ill people against their will."

If you cut loose from the euphemism you can make the problem crystal clear. "Do you think," you could ask, "that your son is insane?" After a momentary shock: "Oh, no; he is not insane. No one in our family has ever been insane." "But you see, if a person is sane, he cannot be kept in a hospital against his will. Legally, it is one or the other. Your son, being sane, is lawfully entitled to leave and we can not hold him against his will."

A change in terminology will be effective only for a very brief period unless it is supported by a change in attitude too. I doubt if the terminologic change from "asylum" to "hospital" is responsible for the conceptual change from a place of refuge to a place of treatment. A change in words without a change in attitude is futile: this much is too obvious to labor here. The real questions are whether a change in words facilitates a change in attitude and whether a change in attitudes is possible if the old term persists. One might assume, *a priori,* that the personnel assigned to a "rehabilitation ward" would show more optimism and zeal than those assigned to an officially designated "chronic ward." But I know of no objective evidence that this is true. If, in fact, patients on this ward are hardly ever rehabilitated, the new label will soon lose its patina. And if, in fact, this ward shows a high return-home rate, the personnel will develop a sense of accomplishment, made all the more exciting if the ward retains its blunter designation of "chronic" or "continued treatment" or even "back" ward.

It is the operational meaning that gives emotional color to the word. No matter what the dictionary says, or what we conjure up in our conferences or committees, it is the word *in operation* which counts. If we improve the operation, we do not need to sweeten the word. And if we fail to improve the operation, it is a futile bit of word play to invent a new term. The true meaning always wears through the verbal varnish. To pretend otherwise is to yield to a plausible delusion.

HENRY A. DAVIDSON, M. D.

---

Es gibt keine patriotische Kunst und keine patriotische Wissenschaft. Beide gehören, wie alles hohe Gute, der ganzen Welt und können nur durch allgemeine freie Wechselwirkung aller zugleich Lebenden gefördert werden.

GOETHE

# NEWS AND NOTES

**Norman Cameron Heads Psychiatry at Yale.**—Announcement has been received of the appointment of Dr. Norman Cameron as professor of psychiatry at the Yale University School of Medicine, effective July 1, 1953.

Dr. Cameron holds an M. D. degree from Johns Hopkins University and a Ph. D. degree from the University of Michigan; has had unusually varied experience in both psychiatry and psychology, having headed both departments at the University of Wisconsin; and has also been a member of the teaching staff of Cornell University Medical College and at John Hopkins Medical School.

---

**First International Committee of Group Psychotherapy.**—This committee announces the first international congress to be held in connection with the International Congress of Mental Health in Toronto in 1954. It is planned that the congress will be representative of all varieties of group psychotherapy.

The organizing committee consists of J. L. Moreno, M. D., director; Austin M. Davies, consultant secretary; the sponsoring committee includes: Joshua Bierber, M. D., Institute of Social Psychiatry, London, England; Juliette Boutonier, M. D., University of Strasbourg; Jean Delay, M. D., University of Paris; Rudolf Dreikurs, M. D., Chicago Medical College; S. H. Foulkes, M. D., Maudsley Hospital, London; George Heuyer, M. D., University of Paris; Marcel Montassut, M. D., Hospitaux de la Seine, Paris; J. L. Moreno, M. D., Moreno Institute, New York; Winfred Overholser, M. D., St. Elizabeths Hospital, Washington; Wellman J. Warner, Ph. D., New York University; and Yves Porc'her, M. D., Hospital Henri Rouselle, Paris. The executive committee includes Leon Chertok, M. D., Victor Gachkel, M. D., Serge Lebovici, M. D., and F. Pasche, M. D.,—all of Paris; P. Senft, Ph. D. and E. N. Snowden, M. D. of London; Erwin Stransky, M. D. of Vienna and H. Teirich, M. D. of Graz; Walter Bromberg, M. D., Sacramento; Robert Drews, M. D., Detroit; James Enneis, M. A., Milledgeville, Ga.; Robert B. Haas, Ph. D., Los Angeles; and Joseph I. Meiers, M. D. of New York.

Those wishing to participate in the Congress are invited to write to the International Committee of Group Psychotherapy, 101 Park Avenue, New York City 17, New York.

---

**Lecture Series at North Shore.**—Theme of the fourth annual North Shore Health Resort lecture series, given at the hospital in Winnetka, Ill., the first Wednesday of every month at 8:00 p.m. from October 1953 through June 1954, is "Treatment in Psychiatry."

Dr. Harold G. Wolff of Cornell University Medical College will open the series on October 7, speaking on the problem of psychiatric referral. Topic for the November session is: "What is Psychoanalysis?"; Dr. Marc H. Hollander of the University of Illinois will deliver the lecture, followed in December by Dr. Rudolf Dreikurs of the Chicago Medical School with "What is Psychotherapy?" In January Dr. Howard P. Rome of the Mayo Clinic will discuss the role of a psychiatrist in a hospital; in February, the use of shock therapy and psychosurgery will be discussed by Dr. Lothar B. Kalinowsky of the New York State Psychiatric Institute and Hospital. Speaking on the role of the family in emotional disorders, Prof. Jules Henry of the anthropology department of Washington University in St. Louis, Missouri is to deliver the lecture in March. Invited to give the lecture in May is Dr. Kenneth Appel, president of the APA and professor of psychiatry at the University of Pennsylvania. Dr. Daniel Blain, medical director of the APA, will complete the series in June with a discussion on how the general practitioner can contribute toward healthy emotional development.

These lectures are open to all physicians without charge. Further information may be obtained from Dr. Samuel Liebman, medical director of the North Shore Health Resort, 225 Sheridan Road, Winnetka, Illinois.

**Nineteenth Postgraduate Seminar in Neurology and Psychiatry.**—The Massachusetts Department of Mental Health announces a review course in basic neurology and psychiatry, consisting of 30 lectures, held every Monday from October 5 to December 7, under the auspices of the Metropolitan State Hospital and the Psychiatric Training Faculty of Massachusetts. Directed by Dr. William F. McLaughlin, this section of the seminar is being conducted at the Metropolitan State Hospital at Waltham.

From October 7 to December 2 at the Walter E. Fernald State School at Waverly, Dr. Malcolm J. Farrell is conducting a course in pediatric neuropsychiatry, consisting of 8 seminars covering different aspects of dynamic and developmental neuropsychiatry, including problems of childhood schizophrenia, mental deficiencies, emotional reactions, and cerebral palsies. Each seminar is a 2-hour session with one speaker as chairman and other speakers as invited guests at a round-table discussion.

---

**Second International Congress of Cardiology.**—The Second International Congress of Cardiology will be held in Washington, D. C., September 12-15, 1954, to be followed immediately by the annual scientific sessions of the American Heart Association, September 16-18, 1954. The opening session will be held in the auditorium of Constitution Hall at 10:30 on Sunday, September 12, 1954. A reception will be given at the Mayflower Hotel at 5:00 p.m. on the same day for all Members of the Congress and their families. A banquet will be held September 15, 1954 at 7:30.

The Scientific Sessions lasting for 3 days will include formal papers, panel discussions, clinical pathological conferences and visits to important medical centers in Washington and Bethesda. The program will be printed in French, Spanish, and English. Immediate translation of some of the papers and discussions will be made in 3 languages.

A series of postcongressional visits and conferences to at least 20 of the leading cardiac clinics in different parts of the U. S. and Canada has been arranged by special committees of local Heart Associations in the various cities.

**Carbon Dioxide Research Association, Inc.**—This association, incorporated under the laws of the State of New York on June 26, 1953, succeeds the Committee on Carbon Dioxide Research. Dr. Albert A. LaVerne of New York is president of the organization; first and second vice-presidents are, respectively, Drs. L. J. Meduna of Chicago and Robert B. McGraw, New York City. The corresponding secretary, to whom all inquiries regarding membership and all requests relative to the use of carbon dioxide in psychiatry should be directed, is Dr. A. I. Jackman, 8 South Michigan Avenue, Chicago 3, Illinois. Dr. John D. Moriarty of Los Angeles is the recording secretary and Dr. Robert E. Peck of New York, the treasurer. The membership fee is $5.00.

---

**Symposium at Embreeville State Hospital.**—Dr. J. V. Cohn, superintendent of the hospital announces that a symposium with the theme, "Whither Psychiatry?" constituting the first annual postgraduate seminar in psychiatry, will be held at the hospital, Tuesday, October 27, 1953. Speakers will be Dr. Daniel Blain, Dr. Crawford N. Baganz, Dr. Lauren H. Smith, Dr. Arthur P. Noyes, Dr. Frederick L. Weniger, and Dr. Kenneth E. Appel.

After dinner in the evening, Dr. Clarence P. Oberndorf will speak on the place of psychiatry in contemporary civilization.

Luncheon and dinner will be served, for which a charge will be made. Overnight accomodation can also be arranged. There is a registration fee of $2.00. Those wishing to attend the seminar will please write to Dr. Cohn and make advance reservations.

---

**Archivos de Criminologia, Neuro-Psiquiatria y Disciplinas Conexas.**—After an interval of several years, during which this journal lapsed, it has now been reinstated in a new series. Volume I, Number 1 has appeared representing the quarter, January to March 1953, under the editorship of Dr. Julio Endara.

The Archivos is the official organ of the Institute of Criminology of the Central University of Ecuador at Quito and is published in that city by the Casa de la Ecuatoriana.

**General Hospital Psychiatric Service.**—Another general hospital to fall in line with plans to deserve the designation "general hospital," that is, a more nearly *complete* hospital, by providing psychiatric inpatient services is St. Vincent's Hospital in New York City. This institution, located on West 12th Street, has announced that the erection of a separate 80-bed unit devoted entirely to psychiatric treatment and costing $2,500,000 will be begun in the spring of 1954. It will be a 7-story building situated on West 12th Street, east of Seventh Avenue and north of the present hospital site. The architects foresee its completion by autumn 1955.

---

## SUICIDE POEM

About the year 2000 B. C. a man of Egypt, weary of life, his body painfully mutilated and disfigured, perhaps by enemies, committed to a strip of papyrus these lines before taking his own life. "I doubt," writes Egyptologist Arthur Weigall, "whether in the whole world's literature, Death has ever been portrayed in more alluring fashion or so sweetly sung."

Death is before me to-day
Like the recovery of a sick man;
Like going out into the garden after an illness.

Death is before me to-day
Like the fragrance of myrrh;
Like sitting under a ship's sail on a windy day.

Death is before me to-day
Like the scent of lotus flowers;
Like resting on the roadside to drink deep.

Death is before me to-day
Like the course of the overflowing water-channel.
Like the return of a man from a ship of war to his house.

Death is before me to-day
Like the clearing of mist from the sky;
Like a man fowling therein toward that of which he was not aware.

Death is before me to-day
As a man craves to see his home
When he has spent years in captivity.

# BOOK REVIEWS

PATTERNS OF MARRIAGE: A STUDY OF MARRIAGE RELATIONSHIPS IN THE URBAN WORKING CLASSES. By *Eliot Slater, M.A., M.D., F.R.C.P., and Moya Woodside.* (London: Cassel & Company Ltd., 1951. Price: $3.75.)

Like some gigantic and inhuman experiment, warfare throws together millions of human beings in a manner that could never be duplicated in peace time. In this general ill wind one accidental good result (from the research standpoint) is that large numbers of men are subjected to the same stresses in what amounts to a loosely controlled experimental situation.

During the Second World War psychiatrist Eliot Slater and psychiatric social worker Moya Woodside found themselves attached to a large London military hospital, with one medical-surgical wing, the other wing reserved for neuropsychiatric cases. Slater and Woodside were interested in finding out whether neurotic men married neurotic women. They found out that they did. But the investigators found out a great deal more about their normal and psychoneurotic married samples. (The wives in all cases were extensively interviewed.) This material is now available in their joint book, "Patterns of Marriage." Some of these findings are to be expected and form statistical confirmation of what most clinicians agree upon. For example, that unhappiness in the childhood home predisposes to neurosis later on in life; that a happy childhood and subsequent stability are largely dependent upon the personality of the mother; that neurosis in childhood frequently leads to neurosis in adult life. Or again, that psychoneurotics tend to be socially inept, that they rarely have hobbies, that their reading is generally of the murder mystery, time-killing sort—or none at all. Or again, that in the happy marriage such things as temperament, attitudes, companionship, and a community of interests are more important considerations in making the marriage stick than orgastic proficiency.

Some unexpected findings (this is, of course, a small sample) were the large number of normal controls with extremely traumatic childhood backgrounds and the odd discovery that the wives of neurotics tended to have had unhappy childhoods, like their husbands. However, success or failure in marriage was found not to be a question of individual factors, but a complex of traits, for which this book must be consulted.

Such a book calls for comments on certain trends in psychiatric writing. Probably in some quarters "Patterns of Marriage" would be termed "superficial." In the current psychiatric jargon this is a term of abuse frequently heard nowadays, most often from the cultist fringe of our specialty. Mesmer and Paracelsus had similar language of vilification for the science of their own age. For to those well-intentioned gentlemen, now dimly seen through the perspective of history as picturesque mountebanks, the struggling science of the day must have seemed earthbound, snail-paced and unattractive, with its dogged concern for reality, its integrity, and its emphasis upon the matter and discipline of science as a public enterprise inviting all properly qualified investigators to participate. In the soundest scientific tradition "Patterns of Marriage" is a type of psychiatric literature that may well boast of its "superficiality," for it subscribes to no cult hero, contains no secret, unsubstantiated lore; its methodology is scientific, not cultist; its central business is the recording of facts, not the exegesis of doctrine; and it is entirely innocent of pontifical utterances.

However, "Patterns of Marriage" is good, solid fare and will prove invaluable to the clinician, student, psychiatric social worker, and all who are engaged in marriage counseling or are students of its problems.

H. K. JOHNSON, M. D.,
Rockland State Hospital,
Orangeburg, N. Y.

PHYSIOPATHOLOGIE DU SYSTÈME NERVEUX, DU MÈCANISME AU DIAGNOSTIC. Third revised edition. By *Paul Cossa.* (Paris: Masson & Co., 1950.)

The author, a pupil of Babinski, Claude, and Vincent, presents in an admirable way the data of modern neurophysiological pathology that are most helpful for clinical diagnosis. The presentation of the normal mechanisms, results of experimentation, supporting theories and historical sidelights add to the fullness of this worthy achievement. The 329 clear line-drawings, many of which are original, enhance the lucidity of the style and print.

The author states that in the third edition of his text he added the results of "Anglo-Saxon" research in the light of which the work was "rethought" and rewritten.

In his introductory chapter Cossa traces the evolution of the nervous system to its beginning in the amoeba, endowed with irritability that is divided into the 3 more elementary functions: sensibility, conduction, and reaction. The text is divided into 35 chapters grouped in 4 parts: (1) general, normal, and pathological neurophysiology, (2) analytical study of the functions of the nervous system, (3) the function of vegetative life, (4) the nervous system and the life of the psyche.

In discussing the Nissl bodies in the cytoplasm of a nerve cell, the author recalls the controversy as to the existence of these granules, until it was finally confirmed by Lenhosseck and Berthe. A special chapter covers the experimental studies in elementary nervous activity—excitability and conduction—with special attention to chronaxies and

Lapicque's theories. In the theories on the various levels of neuronic excitability, some (Goepfert, Coppée, Eccles, *et al.*) claim that the inflow of motor energy is arrested on the threshold of the motor nerve's end plate, where a potential of an electric nature is created. However, according to Sherrington, there is already in existence a central excitation state in which physical support causes a somatic polarization of the cell, cathoelectrotonic in excitation and anoelectronic in inhibition. The nerve cell is thus never in a neutral state even before it receives the nervous impulse.

Further on the author reviews the functional interrelations of the neurons with the theories of Lapicque, Niveau, Sherrington-Lorente, No, and Eccles. In the study of reflex activity the opinions of Flueger, Chauveu and Sherrington are quoted. The functional levels of the mammalian nervous system are explained by the observation of spinal and decerberate animals and men. He accepts the Cushing—Zand hypothesis on the choroid plexus origin of the cerebrospinal fluid.

In treating the various aspects of sensation, the author states that when a leucotomy is performed to abolish unbearable pain, the pain sensation remains, but its affect is lost. The physiology of the special senses is treated in great detail aided by illustrations of exceptional excellence.

The author deals further with the kinetic segmental and intersegmental reflexes and those of the statokinetic type; the automatic and associate motility giving the new theories about the thalamostriate. Describing the voluntary motility of the pyramidal system, the author gives us in great detail the results of its extirpation. Epilepsy, generalized and localized, is treated as an excitation and "liberation." The various ataxias are described in the chapter on the regulations of movement. The oculomotor apparatus has received a special emphasis and is followed by a well-organized presentation of the physiopathology of the peripheral syndromes.

While describing the normal physiology of the vegetative nervous system, the author gives us the 6 names by which various authors identify it: vegetative, autonomic, involuntary, organovegetative and olosympathetic. He criticizes the theory of Reilly (on tonus and excitability) and does not accept the notion, first promulgated by Eppinger, that the sympathetic and parasympathetic divisions of the vegetative nervous system always "pull" in completely different directions.

A welcome addition to this valuable work on the nervous system is the part investigating the relations between the nervous system and the psyche: the mechanisms of sleep, the instinctual—affective life; the sensory and motor localizations in the cerebral cortex; the sensation of space, time, gnosis and agnosis; the aphasias and electroencephalography (written by Drs. Gastaut and Remond).

The problem of conditioned reflexes brings in the Russian reflexological school represented by Pavlov, Bechterew, and Ischlondsky. In recent years eminent physiologists, neurologists, and psychiatrists were purged for nonconformity with Pavlov's theories on reflex activity. However, Liddel has shown that Pavlov's observations were made on experimental animals in abnormal conditions and are thus not applicable to normal functioning. Pavlov's claim that the reflex center is limited to the cortex has been disproved by the experiments of Nikitris, Puussep, Mettler, and Rosenthal.

In the discussion of the physiological bases of intellectual activity, he quotes Penfield, who has shown that consciousness is not limited to the cortex, for the former survives when the latter is extirpated. Functional localizations in the cortex are viewed in the light of the hypotheses made by von Economo, Lhermitte, Brugia, Jackson, von Monakow, and Kurt Goldstein. The author concludes this chapter by promulgating his own theory on the hierarchy of the activities of the nervous system manifesting a progressive effort to liberate itself from the influences of the external world.

HIRSCH L. GORDON, M. D.,
Metropolitan Hospital, N. Y. C.

MIDCENTURY PSYCHIATRY. Edited by *Roy R. Grinker*. (Springfield: C. C. Thomas, 1953. Price: $5.50.)

When the Institute for Psychosomatic and Psychiatric Research and Training of the Michael Reese Hospital in Chicago was dedicated on June 1, 1951, a group of scientists spoke on varying aspects of midcentury psychiatry; their multidisciplinary contributions are recorded in this book, edited by Roy Grinker. The essays are excellent and provide a symposium that can be highly recommended to all those interested in human behavior.

Percival Bailey's essay entitled "Cortex and Mind" is a philosophic and physiologic discussion with some theologic overtones. He compares the cerebral cortex to a machine for handling signals.

In his chapter entitled "Neurophysiology in Relation to Behavior," Ralph Gerard emphasizes the importance of electrical field effects as part of the important mechanisms in integrating the neurons in their interactions. Incidentally, he has faith in the idea that the solution of the problem of schizophrenia rests in the study of cell chemistry.

George Engel, in a thorough discussion of homeostasis, reviews the contributions of Charles Darwin, Claude Bernard, and Sigmund Freud to the unitary concept of health and disease. He emphasizes that the physician must understand man's basic needs and his means of adaptation in a physical, organic, and social environment.

David Shakow excellently elucidates a difficult subject and discusses in detail and with wisdom the relations of experimental psychology to psychiatry. He suggests a more adequate study of normal subjects and a systematic exploration of the complexities of psychotherapy, and believes that psychiatry's lack of regard for the applicability of statistics to its problems has been a handicap to the development of psychiatry in the past.

In a well-written essay entitled "The Biology of Wishes and Worries," H. S. Liddell expounds many sobering thoughts with a keen sense of humor. He discusses the rational pursuit of pleasure and its medical importance, emphasizing that the biology of relaxation and the pleasurable con-

sequences of repeated success in the exercise of skills have been relatively neglected.

In a discussion on "Observational Psychiatry" David Levy demonstrates a method of investigation through data acquired by observation and believes that in solving a problem in psychodynamics it is preferable to frame questions that call for pertinent observations rather than dialectics. He discusses self-determined behavior, goal-directed behavior, and what he calls the various "oppositional syndromes."

Charles Johnson does a good job of discussing the influence of social science on psychiatry and he makes a case of the urgent need of a closer rapproachment between psychiatry and the social sciences. He points out the role of culture in personality formation and concludes that in a world of variant cultures and societies the assumption of "universal feelings and attitudes," etc., is out of the question.

Various aspects of psychoanalysis are discussed by Therese Benedek, M. R. Kaufman, Thomas French, and Franz Alexander. The Freudian's penchant for the use of hyphenated terms and for the use of nouns as adjectives appears only 2 or 3 times (in the essay by Benedek). Benedek discusses the organization of psychic energy and the ultimate goal of tracing this energy to its physiologic sources and following its variations under social influences.

Kaufman, like Benedek, reviews the basic postulates of Freudian psychology and does not bring out anything particularly new. He emphasizes, however, that a mental event must also be described from the physiological point of view. Perhaps it is not intended, but his essay seems to imply a certain uncompromising attitude which is at variance with that of Thomas French and Franz Alexander.

It is always refreshing for a nonanalyst to read the various articles and essays of French and Alexander. Here, as usual, their contributions are tolerant and open-minded, and since they admit shortcomings and try to give constructive criticism, they impress the reader with the elasticity and wisdom of their thinking. French raises the question of finding a more flexible dynamic approach to the study of the total personality. He points out that the motives for repression are by no means always the same and that the personifying of the ego and the superego, instead of helping, tends to divert one from the task of analyzing the integrative functions.

Alexander, in discussing the therapeutic applications of psychoanalysis, deals only with the fundamental principles which serve as the basis of all sound psychological methods of treatment. The whole tenor of his essay can best be brought out by quoting his last paragraph: "In recent years a division has become apparent in the still small community of psychoanalysts. On the one side there are those who feel more satisfied with our present knowledge and therapeutic techniques, who are apt to look suspiciously upon innovations, and who try, therefore, to preserve psychoanalysis in its original form. This attitude is opposed by those who are keenly aware of the gaps in our theoretical knowledge and of the weak spots in our therapeutic procedure. No matter which of these two attitudes is more valid, it is certain that the mere repetition of routine and the denunciation of every new suggestion as a threat to the purity of psychoanalysis can only lead to stagnation. Let me conclude by emphasizing that further improvements of our therapeutic methods can only result from a persistent re-examination of our theory and from a relentless experimentation with technical modifications."

T. L. L. Soniat, M. D.,
Alton Ochsner Medical Foundation,
New Orleans, La.

This Is Your World. *By Harry A. Wilmer, M. D., Ph. D.* (Springfield, Ill.: Charles C. Thomas, 1952.)

Insofar as this book deals with tuberculosis, it may be divided into 3 parts, namely:

1. *The Early Period—You and Your Visitors.* The "early period" is devoted to "living with tuberculosis" and outlines the patients' natural reactions (anger, anxieties, depression, and fears), the necessity of adjusting to people, the appreciation of "cure" and an understanding of the role of visitors. It is difficult but essential that a patient accepts his new surroundings, the complete authority of nurses and doctors, the so-called "stigma" but necessary segregation and the socio-economic effects of his hospitalization. The natural reactions, if accompanied by understanding and hope, are healthy and make the patient more alert and more capable to successfully fight the infection. There is no shame in tuberculosis and a graceful "do nothing" attitude is to be desired. The fears and misinformation of friends and relatives are universal and understandable but can be overcome by frank discussion, realizing that visitors also have their own worries, that their visits will undoubtedly decrease but their acceptance of your present status will assist you, in the future, to be accepted in your community.

2. *The Middle Period—You and Your Sanatorium.* It is easier to become cured in sanatorium than at home and reactivation is less likely to occur if one waits for official permission to go home. A patient should guard against becoming self-centered, the tales and fears of "old-timers," and the monotony of sanatorium regime. For facts, ask your doctors but realize that, though they are primarily interested in your cure, there are not enough physicians per patient and that the former are also human and have their own share of worries and frustrations.

3. *The Later Period—You and the Outside World.* The fears of going home are intensified by the realization that people outside of sanatorium will not understand the necessity of continued convalescence. On discharge, therefore, a patient should be firm, tolerant, live his former rules, and patiently explain and teach the important public health and personal aspects of tuberculosis. The patient should also accept the proven fact that all forms of therapy are secondary to rest and that his behavior after leaving sanatorium is the most important factor in reactivation.

*Further Comments*—Tuberculosis is a disease of all classes of society and the same neurotic trends

and abnormal personality traits found in any cross section of society, no more or no less, will be found in tuberculosis patients. The neurotic trends may be the result of the restrictions of sanatorium life and the experiences associated with chronic diseases, for example, social insecurity. One must recognize and study the anxieties of the patient and background of his particular problem. No examination is complete without a study of the personality and social adjustments of the patient.

Tuberculosis is now placed on the list of psychosomatic diseases even though tuberculosis is produced by the tubercle bacilli, and it is believed that many psychosomatic manifestations noted in tuberculosis patients play a major role in the aetiology, progress, and recovery of the disease.

The records #1181, 1183, and 1185 have been prepared and follow more or less the same plan as the book. They would be useful to speakers when addressing certain groups.

J. F. Simpson, M. D.,
Ontario Department of Health,
Toronto, Ont.

The Psychology of Thinking. By *W. Edgar Vinacke*. (New York: McGraw-Hill, 1952. Price $5.50.)

This volume, by an associate professor of psychology at the University of Hawaii, undertakes a systematic discussion of facts and theories related to thinking. There are included such varied but kindred topics as consciousness and the field of attention, ideas, imagery and imageless thought, the mechanism of thinking, logic, concept formation, problem solving, imagination, autistic thinking, creative thinking, the internalization of experience, and attitudes.

Central affectional relationships are stressed as vital factors in the internalization process. Ethnocentrism is a specific instance of such internalization.

The author believes that the central-peripheral or motor theory of thinking, along lines first suggested by William James, is much more tenable than the theories holding that thinking is purely a central phenomenon. Thinking is a process having both outer and inner determinants. Outer determinants are most likely to prevail in logical thinking, in the laboratory type of concept-forming and transfer situation, and in problem-solving. Concepts constitute complex systems of organizing meanings that link stimuli with the individual's past experience. In contrast with the foregoing, imagination is determined more by inner conditions. Under imagination, a distinction is made between those processes evoked primarily by external stimuli, although determined chiefly by inner tendencies, and those that are evoked as well as influenced primarily by internal stimuli. To the former the name of imaginative thinking is given. Examples are play and projective tests. The latter are classified as autistic thinking, and include fantasy, dreams, and wishful activity.

There is effort to relate light cast upon the processes of thinking from the treatment situation to facts and theories concerning thinking evolved from a wide range of experiments and observations in situations other than that of therapy. A large amount of stimulating material is brought together.

Richard L. Jenkins, M. D.,
Veterans Administration,
Washington, D. C.

The Changing Years: What to Do about the Menopause. By *Madeline Gray*. (Garden City, N. Y.: Doubleday & Company, 1952. Price: $2.75.)

This reassuring book is written for the women (some 18 million in the United States every year) who are undergoing the changing years of middle age. Based on the ancient principle that knowledge casts out fear, its aim is to counteract the old wives' tales and superstitions that handicap so many women at this time. It is packed with information, helpful suggestions, and human interest stories by way of illustration. The author is sure of her facts (she includes an impressive list of 29 authorities whom she consulted) and, what is more important, she is sure of her values, as the chapter on "Love after Forty" will attest. This chapter alone would make the book outstanding. Largely because of the philosophy expressed here I should like to recommend the book especially to the women who might not think of reading it: girls in late adolescence. Armed with knowledge of the body's natural processes and a wholesome concept of marriage they would approach the later years with confidence.

Judging by the author's experience with a surgical menopause and by tales told by friends of similar experiences, a good many surgeons would profit by reading this book to gain an understanding of the woman's point of view.

The book includes a bibliography for further reading and an index.

M. V. L.

Rorschach's Test III. Advances in Interpretation. By *Samuel J. Beck, Ph. D.* (New York: Grune & Stratton, 1952. Price: $5.50.)

It becomes obvious on reading this book that the author is presenting not isolated facts but an intimate understanding of human behavior and an exposition of the extent to which it can be evaluated by the Rorschach test. Personality is complex and the text avoids oversimplification. In a time when condensations, abstracts, and introductions seem the order of the day, it is a real asset to have a publication addressed not to the beginner or the "interested," but to the serious student.

Beck places proper emphasis on the evaluation of the personality structure *per se* and its psychodynamics, and only secondarily does he offer implications for diagnosis, prognosis, and therapy. The text is so written—and this is a distinct advantage—that it does not lend itself for use as a "cook-book" for test diagnosis. Test responses are seen by the author as reflecting the subject's experience of life, which is not directly related to his overt behavior. The synthesis of the raw data into a description of the personality structure and the translation of these terms to those of probable

manifest activity, and to current psychiatric nosology, are meticulously illustrated by the 4 case studies presented. Beck describes the final interpretation as a blending of experience with the Rorschach test, empathy with the data on hand, understanding of the psychodynamics, and use of the appropriate psychiatric terminology.

Perhaps the only disappointment is that Chapter II, "Advances in Interpretation," is only 49 pages in length. The case studies that follow, however, serve as "a statement of where the Rorschach test, as I use it, is at the present time."

HERBERT DÖRKEN, JR., PH. D.,
Verdun Protestant Hospital,
Montreal, Que.

THE 1952 YEAR BOOK OF NEUROLOGY, PSYCHIATRY, AND NEUROSURGERY. Edited by *Roland Mackay, M. D.*, (neurology), *Nolan D. C. Lewis, M. D.* (Psychiatry), *Percival Bailey, M. D.* (neurosurgery). (Chicago: The Year Book Publishers, 1953. Price: $6.00.)

The section on neurosurgery that was missing in the 1951 edition of the Year Book reappears in the present volume which is larger by about 50 pages than the preceding one. There is no change in the panel of editors.

In opening the section on neurology, Mackay outlines certain major trends in the clinical, research, and treatment fields. One striking feature has to do with cerebral localization. For decades the goal seemed to be to mark out like patches in a vegetable garden with fairly definite boundaries specific areas of the cortex mediating specific functions, overlooking more or less the liklihood of the brain operating as a whole. Latterly a reverse tendency has been in evidence. "It is as if, having taken the brain apart with doubtful justification, we must now put it together again to see it operate."

Electroencephalography is being applied in ever widening fields, but interpretation has not been without confusion because of lack of understanding of the "fundamental meaning of the action potentials or their algebraic summation in the tracings as recorded."

Mackay mentions, as of particular importance, work on the activator and depressor functions of the diencephalon and mesencephalon (Magoun, Jasper, and others) that may throw light on the problems of consciousness and psychic activities and eventually lead to a "better formulation of human behavior in neurologic terms."

Promising work on vaccines against polio and encephalitis is being vigorously carried on.

The editor notes that papers on neurosyphilis rarely appear now, "a most astonishing revolution in neurology and a tribute to the prevention and adequate early treatment of syphilis."

Nolan Lewis in his introduction to the section on psychiatry points to four main trends in current work: psychosurgery, psychosomatics, pharmacologic studies, and psychodynamics.

He notes that the amount of psychoanalytic literature constantly increases but that brief abstracting would be unsatisfactory. He refers to the *Year Book of Psychoanalysis* and especially to the *Annual Survey of Psychoanalysis,* the first volume of which appeared in 1952, as adequate reference sources for those interested in psychoanalytic literature.

Other comprehensive surveys in book form of special fields are *Psychotherapy with Schizophrenics,* which brings together contributions of 14 authors; *Manic-Depressive Psychosis and Allied Conditions,* an excellent review of the literature as covered by 1,200 references; a remarkable volume titled *The Biology of Mental Health and Disease,* issued by the Millbank Memorial Fund, to which 108 authors in a wide range of disciplines contributed.

An up-to-date manual in the field of forensic psychiatry has been long overdue. Two such works were published in 1952: Davidson's *Forensic Psychiatry* and Guttmacher and Weihofer's *Psychiatry and the Law.*

Reinstating, on general demand, the Section on neurosurgery, Bailey takes note of the widespread and increasing interest in this subject around the world. Young surgeons from various countries are training in the United States and returning to their homelands to practice their specialty. Their published reports naturally tend to reflect the special interests of the schools where they trained.

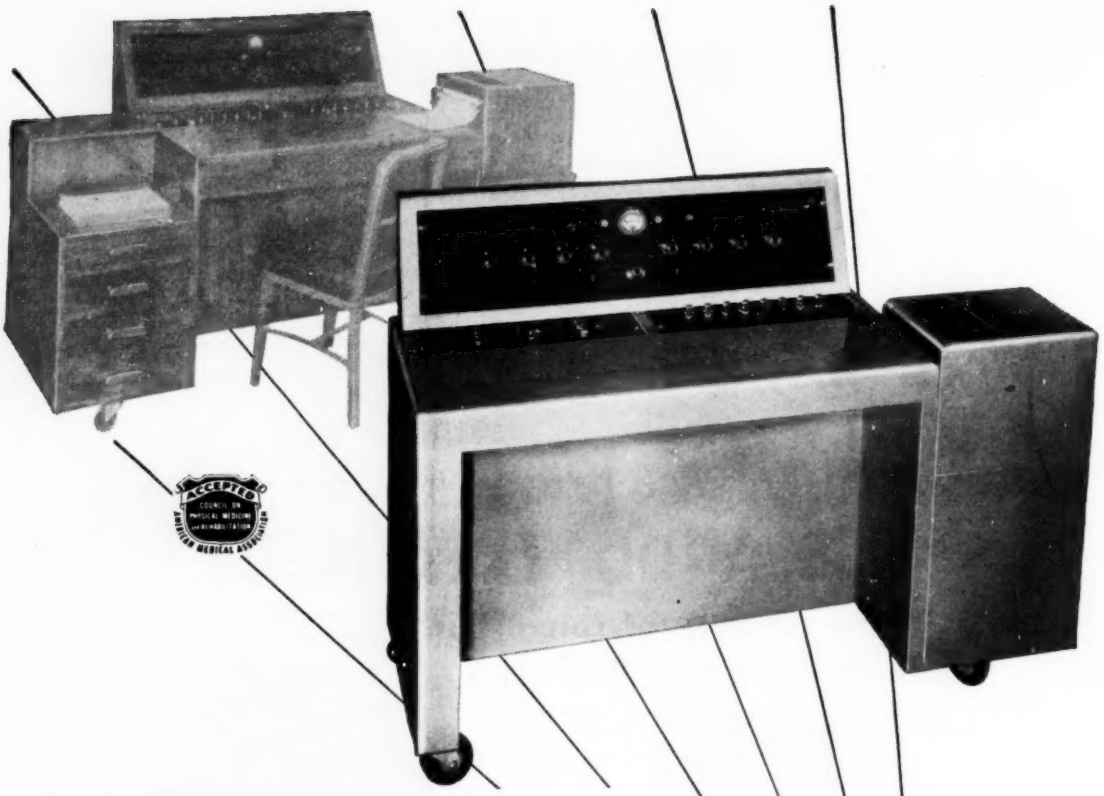
It is interesting but not astonishing that the Russians, true to form, claim priority for many contributions to this field. The editor lists a few as reported by Kromov: the Haidenhain suture of the scalp, use of muscle for hemostasis, development of the bone flap, autotransplants for skull defects, fascia transplants for dura mater defects, repair of brain heruiation, repeated puncture in treating brain abscess, and total removal of brain abscesses with capsules.

For the record Bailey outlines certain milestones in the development of neurologic surgery in Russia, beginning with Bechterew.

The scope of neurosurgery has extended considerably within the recent past, beyond even the remarkable innovations of Harvey Cushing. A few of the new pioneers are mentioned: Frazier (in connection with the spinal cord), Peet and Adson (the sympathetic system), Mixter (herniated disks), Moniz and Lima (psychosurgery).

The *Year Book* does not claim to be all-inclusive. It must be kept within reasonable limits. As it is it runs to 600 pages, including the indices. It offers a fair sampling of the literature of some 20 countries and is amply illustrated. Critical annotations by the editors accompanying a number of the abstracts enhance the value of the *Year Book.*

C. B. F.




ADVANCED FEATURES OF

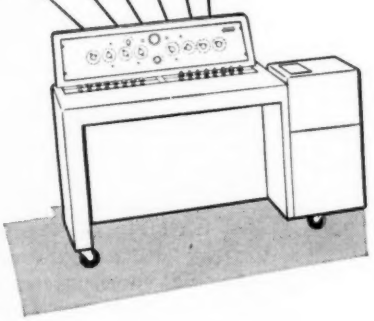
# THE TYPE D3 EEG

## put it years ahead

Most features of modern EEG's were first introduced in Offner instruments.

Compare the features of the Type D3

- Dynograph recorder with over seven centimeters excursion
- Non-Blocking amplifier permitting accurate recording through seizures
- Sensitive non-drifting d-c amplifier for electrophysiological recordings
- All a-c operated with no batteries
- Eight preset lead connections simplifying routine EEG recording
- 24-position Duo-Centric lead selector switches
- Ganged controls making four controls take the place of 40
- Compact metal, or handsome walnut console



***Write for Detailed Information***

**OFFNER ELECTRONICS INC.**

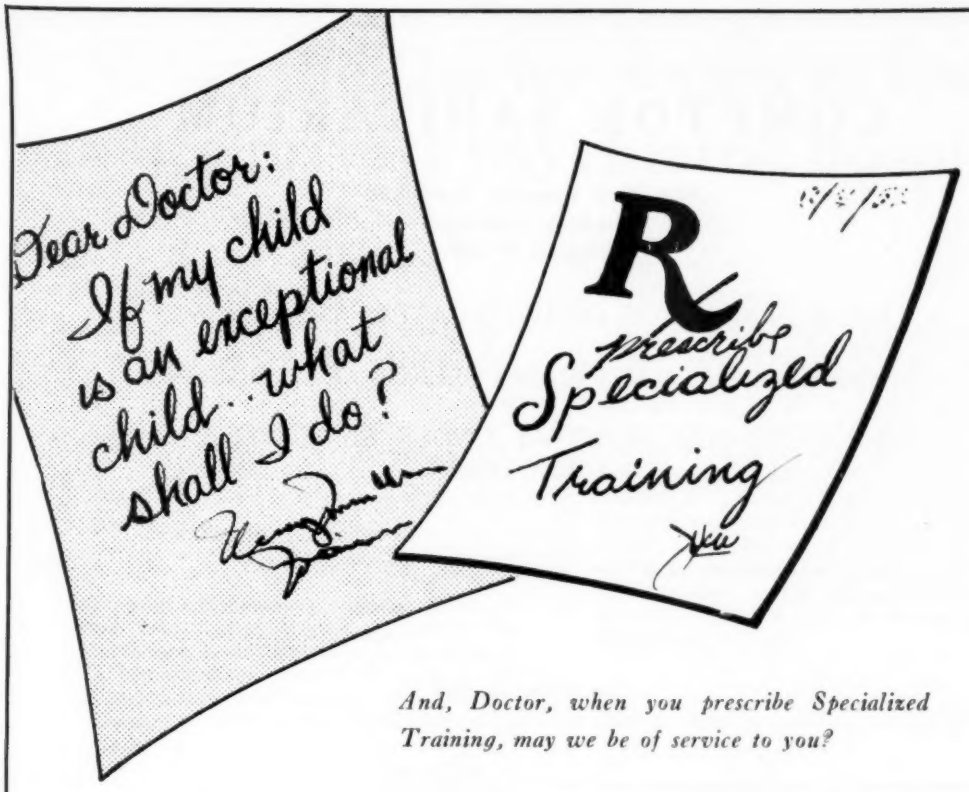
**5320 North Kedzie Avenue**
**Chicago 25, USA**

West Coast Representative:
ROLAND OLANDER AND CO.
7225 Beverly Blvd., Los Angeles 36, California

## "WANTED"

•

This office would like to obtain by purchase or by gift copies of the January 1886, July 1887 and the October 1888 issues of the AMERICAN JOURNAL OF PSYCHIATRY, which are missing from our files. Please notify Mr. Austin M. Davies; Room 412, RKO Building, 1270 Avenue of the Americas, New York 20, New York, if you know of the availability of these issues.




*And, Doctor, when you prescribe Specialized Training, may we be of service to you?*

The Brown Schools is composed of seven separate residence centers, exclusive private schools offering specialized programs of education and re-education for children of all ages with educational and emotional problems.

Suburban and ranch locations in ideal year-round climate; our experienced resident staff of physicians, psychologists, and psychiatrists provides the ultimate in care and understanding of individual cases. Descriptive literature mailed on request.

*Address inquiries to:*
MRS. NOVA LEE DEARING, REGISTRAR
P. O. BOX 4008-D
AUSTIN, TEXAS

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

# The Brown Schools

**BERT P. BROWN, PRESIDENT**

# What the Doctor wants to know about a private psychiatric hospital:

### *"Will the patient get the care the doctor expects?"*

This is the question that most concerns the doctor called upon to recommend the right place for the patient requiring psychiatric care. Hall-Brooke welcomes the doctor who wants to see for himself that this hospital believes in active treatment rather than mere custody. A personal visit is easily arranged since Hall-Brooke is only an hour from New York or Westchester.

### *"How good is the medical staff?"*

The staff is the measure of the hospital. It should have a high professional standing; be large enough to provide the 24-hour coverage and close individual attention the doctor wants for his patient. Hall-Brooke's staff includes Diplomates of the American Board of Psychiatry and Neurology; a doctor of internal medicine, and an associate physician. Consultants in most specialties are nearby. Nursing coverage is provided by 8 Registered Nurses and 21 trained attendants. In all, 60 Hall-Brooke people care for a maximum of 70 patients.

### *"What are the medical facilities?"*

The size of an establishment is important. Hall-Brooke is big enough, with separate buildings set in 120 acres, to provide proper segregation—according to illness, age, and sex—of acute psychoses; psychoneurotic and personality disorders; alcohol and drug addiction; and geriatric patients. Hall-Brooke is licensed by the Bureau of Mental Hygiene, Department of Health, State of Connecticut. Both analytical and dynamically-oriented psychotherapy are used; trained teams, working with the latest equipment, administer electro-coma and insulin treatment—both full shock and sub-coma.

### *"Is the patient's time well-organized?"*

The right kind of care includes keeping the patient occupied to the limit of individual capability. At Hall-Brooke, planned activity supplants guarded idleness. A whole building is devoted to occupational therapy including modern facilities for work in ceramics, metalwork, weaving, leathercraft, painting, sewing, and music. The most important equipment is the helpful interest of the staff in the individual patient. The same spirit shows in the guided recreation on the athletic field, tennis court, putting green; in the trips to the beach and drives through the country; the movie shows and theatre parties.

### *"What is the hospital's relationship with the doctor?"*

Ethical relationships with the referring physician are maintained at Hall-Brooke. Progress reports on his patient are made weekly or oftener. Physician's privileges are extended. As a "therapy hospital," Hall-Brooke tries to help the patient get well, and to restore the patient to the care of the referring physician.

### *"Is the establishment well run?"*

The general impression of the doctor visiting Hall-Brooke is one of confidence in an establishment more than a half century old. In the underlying attitude of competence and consideration visible in the manner of the staff, the well-kept grounds, the tasteful and comfortable furnishings, the high standards of housekeeping and cuisine, the many small amenities of normal living. And in the decent, realistic rates for the wide variety of accommodations.

# Hall-Brooke

**GREENS FARMS, Box 31, CONNECTICUT, Westport 2-5105** • **NEW YORK: ENterprise 6970**

**GEORGE K. PRATT, M.D., F.A.P.A., *Medical Director*** • **MRS. HEIDE F. JONES-BERNARD, *Administrator***

**ENTER NEW SUBSCRIPTIONS AND RENEWALS ON THIS FORM**

AMERICAN JOURNAL OF PSYCHIATRY
1270 AVENUE OF THE AMERICAS, ROOM 412
NEW YORK 20, NEW YORK

..... 19 .....
Date

Enclosed herewith is $ ..... for one year's subscription to the AMERICAN JOURNAL OF PSYCHIATRY beginning with Volume ..... Number .....

NAME .....
Print

ADDRESS .....

SIGNATURE .....

Subscription $12.00 a year or by the Volume. Foreign Postage $1.00 extra (New Volume began July 1953)

# THE ULTIMATE GOAL IS ADJUSTMENT OF THE "WHOLE CHILD"

The psychologic value of all aspects of treatment, training and education are carefully considered for each child at The Woods Schools. The ultimate goal is adjustment of the "whole child," physical, intellectual and social. Each child is taught to handle practical situations, acquire good work habits, accept responsibility, meet social situations, enjoy social experiences, and to function at the maximum of his or her ability as an individual and as a member of the group.

MEDICAL STAFF

Leslie R. Angus, M. D., Director of Psychiatric Services and the Child Research Clinic
William L. Noe, Jr., M. D., Director of Medical Services
Eugene B. Spitz, M. D., Neuro-Surgery Consultant

PSYCHOLOGICAL STAFF

Myrtle E. Wampler, M. A.
Frances Wilmeth, M. A.
Fritz Sterret, M. A.
Ralph B. Ziegler, Jr., M. A.
Frank P. Bekes, Ph. D., Attending Consultant in Speech
Ruth M. Strang, Ph. D., Attending Consultant in Reading

Edward L. Johnstone,
President

## THE WOODS SCHOOLS

*A non-profit organization, founded in 1913*

LANGHORNE, PENNSYLVANIA

**CLINICAL STAFF**

**MEDICAL STAFF OF PENNSYLVANIA**

Robert Donovan, M.D.
Ruth E. Daily, M.D.
Herbert H. Rautenstrauch, M.D.
Robert L. Stott, M.D.
Joseph J. Peters, M.D.
Calvin F. Settlage, M.D.
Albert S. Tenten, M.D.
Walter M. Uhler, M.D.

**PSYCHOLOGICAL STAFF OF PENNSYLVANIA**

Milton Bretton, Ph.D.
Edgar A. Doll, Ph.D.
*Research Consultant*
Michael S. Dunn, A.M.
Robert G. Ferguson, A.M.
Edward L. French, Ph.D.
Marguerite B. Horn, A.M.
John R. Kistler, Ph.D.
Kathryn Kramer
Mary J. Pauling, A.M.
Jack Shelley, M.Ed.

**PROFESSIONAL STAFF, THE DEVEREUX RANCH SCHOOL, CALIFORNIA**

Charles H. Campbell, Jr., M.D.
*Consulting Pediatrician*
Richard H. Lambert, M.D.
*Consulting Psychiatrist*
Ivan A. McAnisz, M.D.
*Consulting Psychiatrist*
David L. Rosen, M.D.
*Consulting Neurologist*

Robert L. Brinker, Ph.D.
*Director of the Ranch School*
Thomas W. Johnston, Ph.D.
*Clinical Psychologist*

# *Vocational Education*

***For the Older Boy or Girl***

**THE older child who has reached the limit of his educational potential finds, at Devereux Schools, opportunity for realistic vocational training and excellent social adjustment. Boys and girls live and work in units adapted to their age and level of mental development. In the Devereux workshops they learn skills suited to their natural abilities. Living in a guided group, they find the social adjustment that helps prepare them for useful community life.**

**You may have occasion to advise parents whose child would benefit from the Devereux vocational facilities. The Devereux staff will be pleased to study the case carefully and offer a detailed report on the possibility of utilizing the Devereux program of education with therapy.**

*Please address your inquiries to:*
JOHN M. BARCLAY, *Registrar*, Devon, Pa.

DEVEREUX FOUNDATION

# *Devereux Schools*

HELENA T. DEVEREUX, *Director*
CLIFFORD SCOTT, M.D., *Executive Director*
SANTA BARBARA, CALIFORNIA • DEVON, PENNSYLVANIA